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AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY

AND

PATHOLOGY

(CHIEFLY FROM ORIGINAL SOURCES).

FASCICULUS XXI., OR XIII. OF NEW SERIES.

SARCOMA MELANODES OF HEBRA.

PLATES CXXXV. to CXXXVI.

ILLUSTRATIONS

OF

RINGWORM, PITYRIASIS, &c.

PLATES CXXXVII. to CXLII.

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ILLUSTRATIONS OF

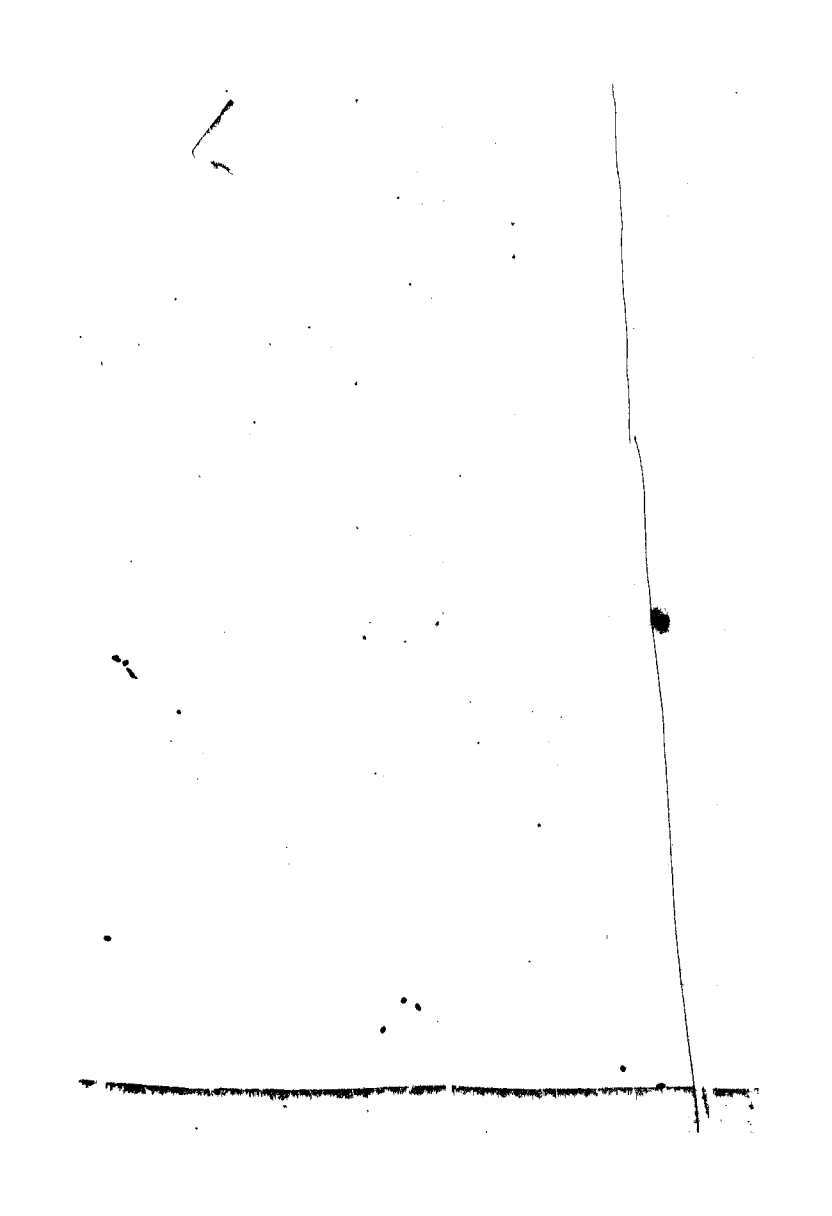
SARCOMA MELANODES OF HEBRA.

PLATE CXXXV.
" CXXXVI.
" CXXXVI.[a]
" CXXXVI.[b]

ILLUSTRATIONS OF

RINGWORM, PITYRIASIS, &c.

PLATE CXXXVII.—Bullous Eruption from Flea-bites.
" CXXXVIII.—Phthyriasis pubis.
" CXXXIX.—Pityriasis rosea.
" CXL.—Tinea tonsurans on the chest of an adult.
" CXLI.—Tinea tonsurans on the back of an adult.
" CXLII.—Lichen scrophulosorum.



SARCOMA MELANODES OF HEBRA.

THE disease which is portrayed in Plates CXXXV.—CXXXVI. has been long known as "The Sarcoma Melanodes of Hebra," and was first observed by that renowned dermatologist in 1868. A full description of it by Kaposi (Hebra's son-in-law and successor) occurs in the fourth volume of our Society's translation of Hebra's work, and three illustrations are given in his folio 'Atlas.' Kaposi's description of the conditions present in Case I. might be accepted almost word for word as applicable to Dr. Gee's patient, from whom our illustration is taken. The name given to the disease by Kaposi was "Idiopathic multiple pigmented Sarcoma," the first term of which was probably intended to imply that the malady begins as a constitutional and not a local one, and that no obvious cause can be assigned for it. Kaposi was emphatic as to the distinction from all those forms of malignant disease which begin by a local growth and become multiple only by infective or, as it was then styled, metastatic transference of plasma. This malady he insisted had no parent growth, but was from the first multiple, and was developed with bilateral symmetry on the four limbs. It always, he said, began on the feet and on both of them at once, and its next manifestation was on the hands and on both of them at once. It will be seen at a glance that in this feature we have a character eminently distinctive from all ordinary forms of malignant disease, none of which, with the rarest exceptions, are in their early stages bilateral.

After citing five cases (see our tabular statement), the main features of the disease were summed up (by Kaposi) as follows:—

"Without any known general or local cause, nodules as large as pigeon-shot, peas, or hazel nuts, and of a bluish- or brownish-red colour become developed in the skin. Their surface is smooth, their consistence firm and elastic; sometimes they are expansile, like an erectile tumour. They are isolated, and, when increased in size, appear as globular prominences. Or, they form groups, and then remain more flattened. In the latter case, the central nodules of the plaque undergo involution and give rise to a dark, pigmented depression. They always occur first on the sole and dorsum of the foot, and soon afterwards on the hands. They develop most abundantly on these parts, and are associated with a diffuse thickening of the skin and deformity of the hands and feet. In the further course of the disease, nodules which are either isolated or arranged in groups occur also on the arms, legs, and face, but they are always fewer in number and irregularly distributed. The nodules may, in part, undergo atrophy and involution. It would appear that they become ulcerated at a late period only, or, more correctly speaking, the part which they occupy becomes gangrenous. The lymphatic glands do not become materially swollen. Finally, similar nodules become developed in the mucous membrane of the larynx, trachea, stomach, intestines, and liver, but, most abundantly, throughout the large intestine as far as the anus. The disease always terminates fatally within two or three years. The cases observed all occurred in men over 40 years of age (Billroth's case excepted).

"In contradistinction to what occurs in Carcinoma pigmentodes, it is to be mentioned that the typical pigment-sarcoma described always began on the feet, and, from thence, gave rise to subsequent deposits which did not correspond to the large lymphatic vessels; that the glands, generally, appeared almost wholly unaltered; and the supposition that the disease might have been propagated by metastasis is also hardly supported by the fact that both feet, and soon even both hands, became affected in like manner and with equal intensity, and with greater intensity than any other part of the body. Whilst it is quite possible for carcinoma to remain a local affection for a long time, and only become a general affection by metastasis, it must be admitted that, in the disease under discussion, a general morbid affection exists from the very outset.

"An examination of nodules taken from Cases I. and II. showed them to have identical histological

characters—groups of small round cells in the corium, small hæmorrhages in the nodules, and abundance of pigment. It could here be demonstrated, more easily than in the Carcinoma pigmentodes, that the remarkable pigmentation was perhaps entirely, or, at least for the most part, due to excessive vascularity, or to hæmorrhages within the nodules.

"According to present experience, the disease must be regarded from the outset not only as incurable, but as fatal. Since it commences almost simultaneously on both hands and feet, and since, for this reason, it must be regarded as a general affection from the beginning, we could not entertain the least hope of checking its pernicious course by an early extirpation of the original nodules, even if the operation itself were practicable."

Although Kaposi cited five cases, it must be stated that only one of them had been observed up to its termination, and it is probable that his estimate of the rapidity of the course usually run was somewhat exaggerated. In the only case in which a *post-mortem* was obtained there were growths, not improbably as the result of self-infection, on some of the mucous surfaces, but no gland disease.

The portraits which illustrate this disease in Hebra's 'Atlas' are given in Heft X., Plate 9. There are three figures—two hands and a foot. The name appended is, "Sarcoma Melanodes (pigment sarcoma)." The value of these portraits and some others relating to the subject is very great, for they supplement the verbal descriptions in a most instructive and indeed conclusive manner. No one having placed the portrait which we now publish side by side with those of Hebra can feel the slightest doubt that they depict the same disease. The foot of Dr. Gee's patient is, in fact, the counterpart of that of Hebra's, with an important difference. The difference concerns the blackness of the discolouration. In Hebra's, the blackness is that suggestive of melanotic pigmentation, but in Dr. Gee's it is rather a brownish red or livid discolouration, and does not suggest melanosis at all. We may not unreasonably suspect that this feature in Hebra's portrait is somewhat exaggerated, for, curiously enough, "reddish brown" is the descriptive epithet used in almost all the German descriptions; and Kaposi himself subsequently proposed to substitute the designation "hæmorrhagic" for "pigmented," and admitted that the discolouration resulted mainly from the blood. Following this conception, Perrin has proposed to place the disease amongst the *non*-pigmented sarcomata. This point is of great importance, for, if the suggestion of primary pigmentation is given up, certain other recorded cases fall into line and give valuable evidence as to the real nature of the changes. The cases of blue discolouration which were published by the writer in Vol. I. of the 'British Journal of Dermatology' were at the time supposed to be separated from Hebra's malady by the absence of the pigmentation and the predominance of vascular changes.* As, however, it is now admitted by Vienna authorities, as well as others, that vascular changes are the principal feature, there remains no reason for their isolation. They are valuable as giving evidence in two directions—first, as to the relationship of the malady to gout; and, secondly, to local injuries. They also suggest that slighter forms of the disease may be transitory, and that the malady is by no means so rapid in its course as Kaposi's earlier statements might seem to imply. In the case given at page 41 of Vol. I. of 'Illustrations of Clinical Surgery' the patient lived eight or ten years from the commencement of his disease, during which time he suffered repeatedly from gout.

It is due to Kaposi's original descriptions to state that, although it seems to be generally admitted that they exaggerated the pigmentation, they by no means neglected the vascular element. Swelling and œdema are definitely recorded, and it is even stated that some of the tumours suggested a cavernous or erectile structure.

In reference to the suggestion of gout, it is to be noted that in all forms of gouty inflammation the venous complication is prominent, and a livid or purple tint with œdema and dilated venules at the borders of the area concerned are conspicuous features. In but

* "On Two Remarkable Cases of Symmetrical Purple Congestion of the Skin in Patches, with Induration," by Jonathan Hutchinson. 'British Journal of Dermatology,' Vol. I., 1888, p. 10.

few of the recorded cases of the disease under consideration does there appear to have been any enquiry made as to a gout history; but it is significant that all were adult men, and that in several of the records it is especially stated that they were well-to-do and robust.

So definite is the preference of the eruption for the hands and feet, that Unna has even proposed to call it Acro-Sarcoma. It never, however, begins at the tips of the digits, and but rarely affects the nose or ears; and the exemption of the parts named clearly removes it to a considerable distance from the truly "acro" affections.

It is a limb disease almost exclusively, but not specially incidental to the extremities of the limbs. The nails as a rule escape, and Raynaud's phenomena do not occur.

STATEMENTS OF AUTHORS.

In Kaposi's 'Hand Atlas' (which was published thirty years subsequently to Hebra's larger work, but which includes its material) we have several portraits relating to this disease. The name is now changed, as has been already noted, from "Sarcoma melanodes" or "Idiopathic multiple pigmented Sarcoma" to "Sarcoma idiopathicum multiplex hæmorrhagicum."

Tafel 301, under this change of name, is a copy of Hebra's plate already referred to, and shows the conditions in an advanced stage of the back of a large adult hand.

Tafel 302 is the foot of the same patient.

Tafel 303 is to be taken in connection with 304 and 305, as they are from the same patient. They show a very peculiar form of the disease, inasmuch as no thickened patches are conspicuous.

The subject of this case was a bald-headed man of middle age. The face of the patient and one hand and one foot are portrayed. No facts as to the case are given, but the portraits show general œdematous swelling of the parts with a dusky livid mottling. All the digits, both of hand and foot, are swollen and dusky. The only exception to the statement that there is nothing of the nature of circumscribed patches, or of tubercles, occurs in the instance of the left eyelids, and possibly of the left ear. On these parts some small tubercles are seen. This is the first case, we believe, in which the face has been found affected.

The last of Kaposi's portraits represents the foot and hand of (apparently) a child (no particulars are given), but the conditions are very characteristic. There are dusky livid or brownish patches and numerous tubercles, exactly such as are shown in our own portrait.

The most recent Atlas of Skin Diseases, that of Jacobi, edited in English translation by Dr. Pringle, gives an illustration of *Sarcoma idiopathicum multiplex hæmorrhagicum* from a model in Neisser's Clinic at Breslau, but gives no particulars of the case. Of the disease in general, it is stated that it

"merits special attention. It first appears on the extremities in the form of bright red lumps, which soon become bluish from hæmorrhage into them. With these growths a superficial sarcomatosis of the skin is soon associated; this is accompanied by considerable pain, and the recent tumours assume all the characters of the original ones, including their blue and livid tint. Further spread to internal organs takes place comparatively seldom in contrast with other rapidly progressive skin-sarcomata; while spontaneous disappearance of separate nodules with pigmentation and atrophy not unfrequently happens. Death as a rule occurs only after a very prolonged period." (See page 123.)

Several of these statements seem to require modification. In a great majority of cases the patches are livid, or bluish, from their beginning, and the tint is due not to hæmorrhages, but to dilated venules, since it can be almost wholly removed by pressure. Most writers agree that the patches are painless. We may accept the statement that death occurs only after a very prolonged period as more near the truth than was the original estimate of Kaposi.

Unna, who writes of the disease under the name "*Acro-sarcoma multiplex cutaneum teleangiectodes*," says of it that it appears in the form of dark blue or bluish-black nodules on the hands and feet, especially on the fingers, toes, and the soles of the feet. He speaks of it as advancing to the trunk, genitals,

and even face, and describes the nodules as "partly dermal and partly hypodermal, the former light reddish-brown, the latter dark and blue." He adds, "these Sarcomata are fuso-cellular-, or angio-sarcomata, and show abundant pigmentation." He does not mention hæmorrhages, and his adjective "teleangiectodes" would imply that he had in view dilated vessels rather than extravasations.

Characteristic Features.

Thus, although we have but very few completed cases on record, and but little in the way of exact microscopic investigation, we obtain, by piecing together the fragments offered by different authors, and especially by collating the various epithets which they have thought applicable, a fairly complete picture of this remarkable malady. It becomes clear that it has but a somewhat doubtful claim to rank as a sarcoma in having any close affinity to other maladies classed under that name. An infective form of chronic inflammation is an expression which fits the facts quite as accurately as does that of a malignant neoplasm. The patches are attended by œdema and vascular turgescence, chiefly venous, and their chief features may be made to disappear by firm pressure. It scarcely ever ulcerates, and it is capable of spontaneous resolution, leaving only a stained scar.

Although in most cases there are present little tumours which project "like currants," and may even become pedunculated, in some instances the changes amount to little more than solid œdema with blood staining. The round cells, which are abundant, and which are supposed to characterize "sarcoma," differ, we may believe, but little from the white blood corpuscles. It is to be admitted that we have but little proof of either hæmorrhage or pigmentation. At any rate, these latter phenomena are adventitious rather than essential. The really essential characters are solid œdema and dilatation of venules, and a livid purplish tint is the conspicuously distinctive feature. Although probably not often bilaterally symmetrical *ab initio*, the eruption tends to become so even in the early stages of its development, and this is a feature which is not shared by any other type of sarcoma or other neoplasm. The facts recorded in proof of tendency to infect the viscera are exceedingly few, and in the great majority of cases it remains from first to last restricted to the four limbs. There is no reason for incredulity as to the spontaneous recovery of some cases, especially of those in an early stage.

Possible Association with Gout.

Finally, its occurrence almost solely in the male sex, and in those of at least middle age and of a robust habit of body, with in some cases a definite history of gout, favour a suspicion that it is in some way connected with gouty proclivities. The suggestion is not that it is directly caused by lithæmia, or is in any strong sense an evidence of active gout, but rather that it is a more or less remote consequence of gout in former generations, and of inherited proclivities on the part of the vascular (venous) system. We know that gouty inheritance does in successive generations predispose to varicose veins, piles, "red-seaweed patches on the face," and other proofs of weak-walled vessels, and it may be that in this affection we have, in the main, another illustration of the same tendency. There is nothing inconsistent with the contention that the alliance of the malady is with inflammations rather than with cancer in the free admission that, in some cases, it does assume features of malignancy. It is well known that in elderly persons, processes in their early stage inflammatory only, and susceptible of cure, may slide on into malignancy, and few will doubt that the distinctions between neoplasm and chronic inflammation are often difficult to draw.

To those who may be zealous to add to our clinical knowledge of this rare and most interesting malady, the hint may be given that note should be taken of all local skin affections which are persistent, and which *tend to assume a purple tint*. If this feature be carefully estimated, it is not improbable

that examples of the early stages and of imperfectly developed forms might soon be multiplied. All such should be watched over through long periods, and if opportunities should occur for microscopic investigation, they should not be neglected. The history of family gout should be scrupulously enquired into and recorded in detail.

A Juvenile Form.

It is very important to establish the fact that—in common with certain other affections involving the general system but having local manifestations—this disease has a juvenile as well as a senile form. It was the latter which alone would appear to have come under the observation of Hebra and Kaposi, although the former mentions a fatal case in a child which had been mentioned to him by Billroth. Respecting this latter, there may be much doubt as to its nature, and the first case which can with confidence be considered to afford an example of the juvenile type of Hebra's Sarcoma melanodes is one recorded with a good portrait by Dr. Judson Bury in the 'Illustrated Medical Journal' (May, 1889). This case has been repeatedly referred to since, and others have been added. No one looking at Judson Bury's plate, or at one subsequently published by Dr. Radcliffe Crocker under the designation of Erythema induratum diutinum, and comparing them with those illustrating Hebra's type, can doubt that they are essentially the same malady. There are, however, important features of difference. In the juvenile form the hands appear to be almost solely the parts affected, and less tendency to diffused infection of the limbs is shown. As in other diseases of young persons, the development is more rapid, and there is also a tendency to spontaneous disappearance. In Judson Bury's case the conditions lasted some years, and their final disappearance has not been recorded. In Crocker's case, after the adjective "*diutinum*" had been applied to them, they rather suddenly disappeared. The dusky livid tint, the tumid, well-defined, and slowly advancing borders are as well characterized in children as in elderly persons. A number of examples of this form have been collected in 'Archives of Surgery,' vol. v., p. 234, and evidence is there given connecting it with inheritance from gouty parents. It is not confined to childhood, but may affect young adults. In one case, the ears as well as the hands were involved. In these cases the history of gout in predecessors is almost always forthcoming.

APPENDIX.

Case in which the patient attributed the beginning of his malady to local injuries.

The following brief statement of a case in which it was thought that local injuries had initiated the disease, is appended in order to illustrate that factor. The usual commencement of the disease in the sole of the foot may possibly be in relation to repeated local irritation sustained by that part. The case is given in detail in vol. v., 'Archives of Surgery,' page 236.

Mr. B——, a florid healthy-looking farmer. In this case, at date of observation, 1887, the backs of hands were of deep purple tint, but without much thickening. There were also patches on the feet and ankles, on the backs of elbows, and fronts of wrists. Trunk, face, and head exempt. The patches were considerably thickened and hard, and everywhere of a dusky purple tint. They were not abruptly circumscribed, and from the borders dilated venules and hardened cords passed outwards. He was of gouty tendencies.

	Age.	
1877.	55.	Incised wound, severe, of right hand.
1878.	56.	
1879.	57.	Lividity around scar of injury.
1880.	58.	
1881.	59.	
1882.	60.	Left hand affected.
1883.	61.	Right leg affected after a wound.
1884.	62.	Patches increasing in size and number.
1885.	63.	
1886.	64.	
1887.	65.	Came under observation with numerous patches.

The table of cases on next page is intended simply to illustrate the subject, and does not make any approach to being complete. Many other cases are on record. It is proposed to continue it in a future Fasciculus. It is part of the plan of this 'Atlas' to keep its pages open to receive additions. Our Editorial Committee will be thankful for any references which may be forwarded to them, and most especially so for the opportunity for investigating any new case.

We have preferred to continue the name "SARCOMA MELANODES" because it is the one originally given by Hebra, and stands at the foot of his type plate. It is desirable, however, that it should always be written with the addition "of Hebra," so that it may be clearly understood that no pathological doctrine is implied. As stated in our text, several other names supposed to be accurately descriptive have been devised, and recently some have used the name of "Kaposi's Malady." For the present, but probably only provisionally, it is better to use the original designation.

TABULAR STATEMENT OF SOME PUBLISHED CASES.*

THE SENILE FORM.

	Case.	Age & Sex.	Parts affected.	Gout History.	Reference.
1.	L. K. (blacksmith).	M., 68.	Hands, feet, and legs. Much swelling. It had commenced a year previously.	No note.	Case I. Kaposi.
2.	B. C. H. (a distiller).	M., 66.	Hands, feet, legs, eyelids, and nose. No enlarged glands. Sloughing ulcer on back of one hand. It had been present fourteen months.	No note as to gout. The man died with diarrhœa and bloody stools a few weeks after admission. He had granular kidneys, and stone in the bladder.	Case II. Kaposi.
3.	Allen E. (healthy-looking man).	M., 45.	Both feet. Eight months' duration. Much swelling. Hands as yet free.	No further notes.	Case III. Kaposi.
4.	A man of well-to-do class.	M., 50.	One foot, in the sole.	No details. The patient did not come under observation again.	Case IV. Kaposi.
5.	A man.	M., 40.	A great number of large painful nodules in sole of left foot.	The patient was seen only once, and no details are recorded.	Case V. Kaposi.
6.	Dr. Gee's case.	M., 72.	Hands and feet, and gradually extending upwards. Present duration five years. See Plate.	A sister crippled with chronic rheumatism. Soft tophi in ears.	Now first published (see Plate description).
7.	Boeck's case (a sailor).	M.	Hands (notes defective). See Plate XXXVI.[a]	Sarcoma was diagnosed. No history obtained.	'Archives,' vol. v., and 'Brit. Journal of Dermatology.'
8.	Mr. B.	M., 60.	Hands, feet, and limbs. Extensive on psoriasis positions and others.	It appeared to have followed injuries. Gout probable.	'British Journal of Dermatology,' vol. i., page 8.
9.	John W.	M., 58.	Hands, feet, fronts of legs, and subsequently the arms.	Repeated attacks of gout during twenty-six years.	Clinical Illustrations.

THE JUVENILE FORM.

1.	Judson Bury's case.	F., 11.	Hands and elbows.	No known gout, but she had herself had rheumatic fever.	'Archives,' vol. v., page 238.
2.	Miss U.	F., 18.	Hands, elbows, knees, and heels.	Strong history of family gout.	'Archives,' vol. v., page 238.
3.	Mr. B. (from Nottingham).	M., 25.	Hands, elbows, knees, and ears. Three years' duration.	Strong history of family gout.	'Archives,' vol. v., page 239.
4.	Radcliffe Crocker's case.	F., 9.	Hands.	Dr. Crocker obtained a clear history of gout. Congenital flexion of little fingers.	'British Journal of Dermatology.'

* It is intended to add to these lists in a future Fasciculus.

PLATE CXXXV.

HEBRA'S SARCOMA MELANODES.

Dr. Gee's patient, whose case is illustrated in the three following plates, is a man of 75, by occupation a rope-maker, and residing in a small country town. He was admitted into Luke Ward, St. Bartholomew's Hospital, on June 24th, 1903, but remained in only a few days, as he did not regard himself as seriously ill. His history was that through life he had always enjoyed good health, but for some years past he had been supposed to suffer from a weak heart. The eruption for which he sought advice had commenced nearly three years ago, and was first noticed on the backs of the hands. It was observed on both about the same time, and very soon afterwards ("a few days") his toes and the soles of his feet were affected. Gradually other patches appeared on his legs; and during the last six months some occurred on the thighs, the trunk remaining free. No hæmorrhages had occurred, and there was no tendency to ulceration.

In the notes which were taken at the time, the man is described as healthy-looking, his face of good colour, but slightly tumid. His viscera were carefully examined, and nothing abnormal was detected. On the soft palate there was a purple patch, resembling those on his skin. His temperatures were habitually slightly subnormal. The urine contained neither albumen nor sugar. The condition of his skin is described as follows:—

CONDITION OF SKIN:—See photographs.

FACE:—Small patches on upper and lower eyelid; right eye. Right ear, small blue patch.

TRUNK:—Very small smooth patches on back.

ARMS:—On back of both hands symmetrical patches, blue-purple colour; slightly raised bleb-like appearance, but quite firm to the touch: patches have definite edges: patch covering end of one finger like a thimble.

LEGS:—Swollen and œdematous up to thighs, more marked on right side. Small nodular masses, flat-topped, many of them pedunculated, purple colour, average about the size of a pea: most marked on right side, but also unevenly distributed on both legs. Patches of brown pigment between. Soles of feet almost entirely covered by purple, sharply-defined patch not definitely raised. On inner side of feet, appearance of hard flinty-looking surface.

* * *

The above notes were taken by Dr. Gee's clinical clerk at the time that the patient was under observation in St. Bartholomew's Hospital. The following refer to a date eighteen months later, when the patient attended at the Polyclinic, and they are in some respects more detailed:—

Dec. 2, 1904.—The patient is still a florid, healthy-looking old man, and, with the exception of "a weak heart," he considers himself in good health. He has not followed his vocation for some years, because he no longer possesses the requisite dexterity with his hands. His eruption, speaking generally, is much as it was at the time that the portraits were taken. On the hands and feet the lividity is decidedly less, and the margins of the patches on the soles, when compared with the portraits, are seen to have remained just what they then were. The lower extremities from the haunch downwards are still swollen, but the œdema is decidedly less than it was, more especially in the right limb. This limb is, however, still larger than the other, and in all respects more severely affected. He is now 76 years of age. He has been a total abstainer from all stimulants for more than two years.

Enquiries were especially directed to the question as to whether there were any gouty proclivities, and the following facts were elicited as to his family:—

He had never heard of any gout in his relatives, nor had he himself ever had any affection of his joints. Several of his near relatives had been "rheumatic," his father having suffered much in one hip, and a sister, still living, being somewhat crippled by it. His father died at 73,

and his paternal grandfather at nearly the same age. Both had, so far as he knew, had good health, but both had, he added, "spoiled good constitutions by heavy drinking" (chiefly beer). His father, in addition to his occupation of rope-maker, kept a public-house, and was his own liberal patron. The subject of our case spent the early part of his life in assisting his father in the rope-walk, and also in the management of the public-house; and, although never intemperate, he used to drink with customers. In middle life he became a total abstainer, took the pledge, and for twenty years wore the blue ribbon with consistency. Ultimately, however, he had, he termed, "nervous collapse" and "a weak heart," and, having been advised to take port wine and bark, he did so for several years. His custom was to take a very small glass of a cheap port three times a day, to which he added tincture of bark. This medicine appeared to do his health good, and on his own and his daughter's testimony he continued it regularly for four or five years. It was during this period that his eruption began and progressed; and at length he became convinced that the wine made the eruption worse, and left it off. For two years or more he has, as already stated, taken nothing, and during this period his eruption has on the whole receded.

Respecting the characters displayed by the eruption, the following details may be of some value:—

Bilateral Symmetry.—Although this feature is fairly well characterized, it is by no means exactly so. Thus the little finger on one hand and the ring finger on the other are those chiefly involved, most of the digits being quite free. The palm of the hand is involved only on one side.

The Palate.—It was noticed on the first occasion that there were patches on the palate. These are now represented on the left side by two patches of the colour of liver, and with scarcely any appreciable thickening. They are not bigger than split peas. On the other side similar patches are attended by a thick and rather firm growth, which extends outwards and involves the gum. This is pale, and shows no lividity. The pharynx is diffusedly plum-coloured, but shows no patches. There are several little blue patches on the lips.

The Ears.—The state of the ears is most interesting. The conditions are most marked in the right ear, but are similar in both. The whole external ear is a little tumid, the helix and lobule especially so. Arranged along the upper curve of the helix, percisely where gout tophi are often seen, is a row of bluish nodules.* These nodules are as large as small peas, but are scarcely at all indurated. They are not inflamed, nor in the least painful. In the lobule is another of these little swellings, very indistinct in its outline, and consisting chiefly of bluish discoloration, with general soft hypertrophy. In the concha there is some bluish discoloration, but no definite patches.

The Nails.—None of the nails are in the least affected by the disease. Those of the fingers are thick, sound, and polished. Nails of the gouty diathesis.†

The Soles of the Feet.—These are uniformly roughened and scaly, and, although somewhat dusky, do not show any papules or margined patches. At their borders, however, it is as if he were wearing very low slippers, the border being everywhere very definite, and characterized by a number of small tubercles. Here the colour is almost black. It might be thought that the affected parts were contracted, but this appearance is perhaps rather due to the œdema of the sound skin above, which gives the latter an overhanging edge.

Ulceration and Hæmorrhage.—At the present time there is not the slightest tendency to ulceration anywhere; but it is reported that two years ago the edges of several patches were

* See a note on "Tophi which are not Chalk-stones," 'Archives of Surgery,' vol. vii. p. 147.

† See 'Archives of Surgery,' vol. iv. p. 250, and vol. x. p. 144.

sore, and that on several occasions rather troublesome bleeding occurred from sores on the sides of the feet.

Neither Pain nor Itching.—The patches have never been either painful or irritable.

Different States of the Eruption.—The eruption presents different features, which may be enumerated as (1) bluish stains; (2) blackish blue patches, but very little thickened; and (3) little nodules which may be aptly compared to small currants, usually of a bluish tint, but sometimes quite black. All of these seem to be capable of spontaneous removal, but are very slow to change. When absorbed they leave discoloured areas which are often a little depressed below the level of the adjacent skin.

Ainhum-like Constrictions.—Several of the toes show ringed constrictions near their bases, just like those which occur in the tropical disease known as Ainhum.

Psoriasis-like Patches on Knees.—In front of each knee is a large patch (as big as the palm of an adult hand) with a margined aggressive border, and showing tendency to subside in its centre. These patches are placed like those of psoriasis, but they have no companions on the elbows.

Nature of Discoloration.—Most of the patches can be made much paler by firm pressure, but in none can the colour be wholly removed. In some which are blackest little or no change in tint results. It seems clear that plugging and thrombosis of venules is one part of the process.

The Eyelids.—At the outer angles of the eyelids and at several places on the forehead and adjacent parts there are bluish discolorations—not to be called patches, but as if little groups of blue currants were just under the skin.

Contraction of Skin.—It is evident in some of the larger patches that the changes are attended by induration and contraction of the affected skin. This is especially evident about the heels, where the affected part is much below the level and very hard.

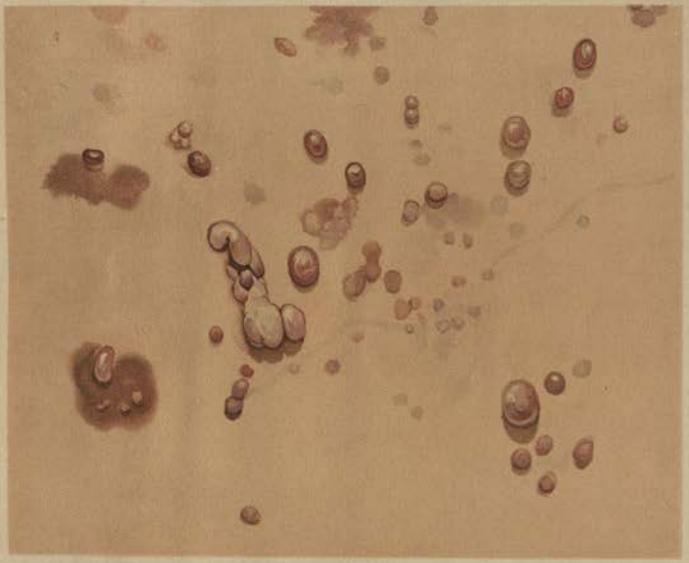
PLATE CXXXVI.

HEBRA'S SARCOMA MELANODES (DR. GEE'S CASE).

In this Plate the artist has given us a more detailed study of the eruption as it occurred on the outer side of the right thigh. The slightly pedunculated little tumours are well shown, and the diffuse discoloration at their bases. The colour is less purple and more florid than it really was.

From nature by Mr. Percival Skett.

This portrait was taken eighteen months ago. At present date (Dec. 1904) most of the little currant-like nodules have flattened down, and some have disappeared. Many flattened and almost black papules, however, remain.



W. Percival Yeats del.

West, Newman chromo.

PLATE CXXXVI[2].

HEBRA'S SARCOMA MELANODES (DR. GEE'S CASE).

The two photographs here given show the arrangement of the patches and tumours on the legs of Dr. Gee's patient. Attention may be asked to the conspicuously œdematous state of the feet. This condition is more or less present in most cases.

PLATE CXV.

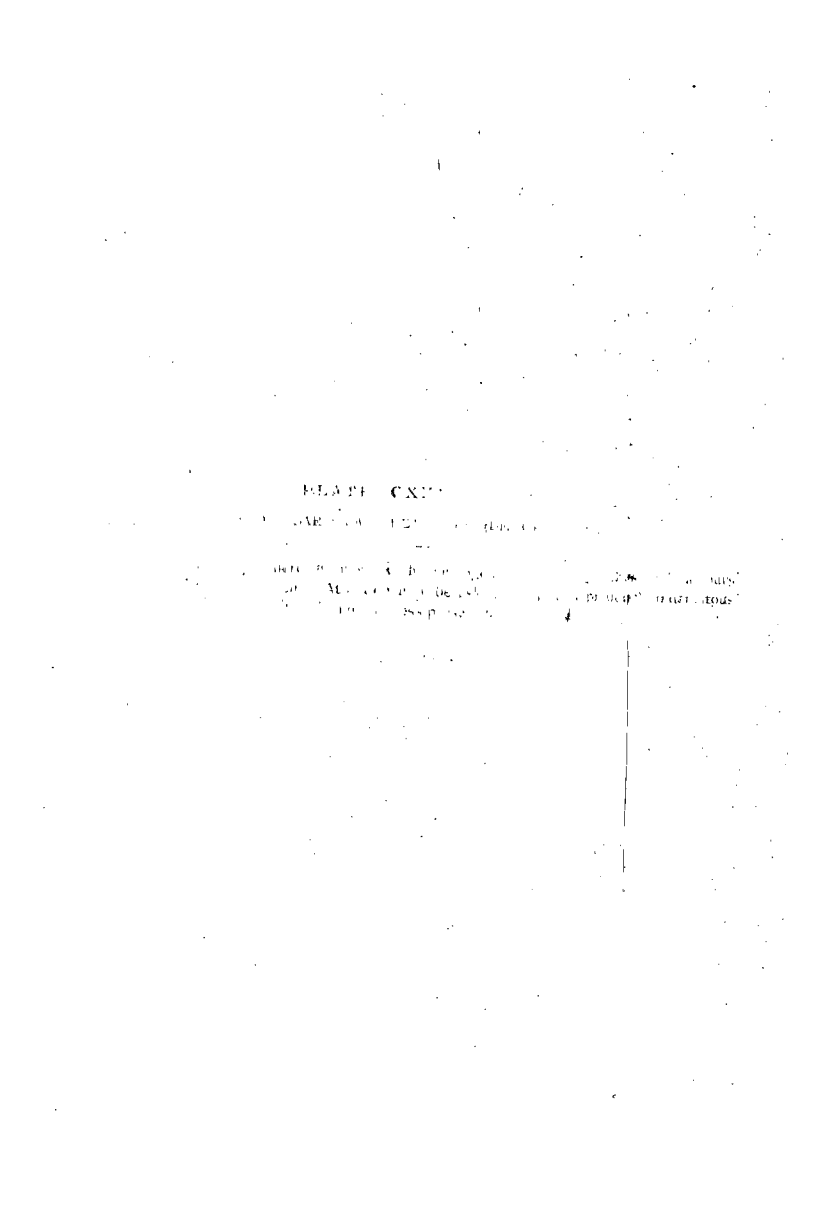


PLATE CXXXVI[a].

THE HAND FROM A CASE OF HEBRA'S SARCOMA MELANODES.

This Plate shows the condition of the hand in the case referred to in the text as having been under Professor Boeck's care in the Christiania Hospital. The original drawing is in the museum of that hospital, but a copy (in colour) is in that of the London Polyclinic. There can be no doubt that it illustrates the same disease as that shown in Hebra's original plate, and also that described in the subjoined narrative. The hand in the latter case is so exactly like that in the Christiania case, that the two have been mistaken for each other. Unfortunately we have no further history of the Christiania case than that its subject was a robust Swedish sailor, and that the disease was regarded, after microscopic biopsy, as a form of Sarcoma. The appended narrative, which conducts a parallel case to its conclusion, becomes, under these circumstances, of additional interest. The narrative is copied from 'Illustrations of Clinical Surgery,' vol. i.:—

John W——, æt 58, was first under my care at the Hospital for Skin Diseases in January, 1869. He came on account of a number of peculiar patches of dark purplish colour on his extremities. The following description is taken from notes written at the time:—On the fronts of his legs, some of his fingers, and on one fore-arm were a number of patches consisting, in the first instance, of distinct tubercles, which afterwards became confluent, and then lost their tubercular character. The patches were peculiar, chiefly on account of their dark purple colour; this tint seemed to depend partly upon venous congestion, and partly upon deposit of colouring matter of the tissues, for although their margins could be made pale by pressure, no amount of squeezing altered the colour of the central parts. The patches were irregular in size and shape, distinctly and abruptly defined, and their surfaces smooth and almost glossy, or sometimes covered with thin, dry, epidermic scales. Their elevation above the surrounding skin was due in great part to œdema, for they could be made to pit by continued pressure, and, in fact, could be squeezed until almost all thickening disappeared. They were neither tender nor painful. The skin around them was slightly œdematous. The patches were distributed on the whole symmetrically, but the symmetry was incomplete. There was a large patch on the front of each leg, that on the left being much the larger. Another large one was present on the back of each middle finger; on the right hand it involved nearly the whole finger, back and front, while in the left the patch occupied only the dorsum of the finger just above the knuckle. There were small separate tubercles of the same nature on the backs of the hands, but these were much more abundant on the right. On the left arm there were two little patches, one above, the other below the elbow, whilst there were none at all on the right arm. Both hands were slightly swollen. The patient stated that the left leg was attacked first, and that the patch in that situation had been present for two years, while that on the right had existed only a couple of months. He was a stout, florid man, engaged at a coal-wharf, and comfortably off. He was liable to attacks of gout, and considered that he had been subject to that disease for twenty-six years. From his account, it seemed that he had had well-marked attacks, but that latterly they had been less severe. He was not aware that he inherited the gout. In connection with the patches on the legs, it should be stated that his veins were not markedly varicose. He remained under care for very nearly twelve months, and during that time the amount of swelling in connection with the patches diminished somewhat, but their colour remained the same. Some fresh patches appeared on the legs; a few of these were at the margins of the former ones, but others, separate ones, came at the backs of the calves, most of them being on the right, and only a single one on the left calf. He had an attack of gout in the metacarpo-phalangeal joint of his left fore-finger while under treatment. No medicine had much effect on the eruption; he took at different times—colchicum and magnesia, arsenic, acid iron mixture, iodide of potassium, and simple alkaline mixture. No special local treatment was adopted, only an ointment of lead and mercury being ordered.

The following is a "space-for-time" schedule of his case:—

	Age.	
1866.	56.	First patch on left leg appeared.
1867.	57.	The first patch still solitary. Liable to gout.
1868.	58.	Patch appeared on right leg, and others on hands and elsewhere.
1869.	59.	Came under observation with multiple developments.
1870.	60.	Patches increasing. General health good.
1871.	61.	An attack of acute gout in finger.
1872.	62.	Eruption increasing very slowly.
1873.	63.	Not under observation.
1874.	64.	" " "
1875.	65.	" " "
1876.	66.	Health failing, and eruption still increasing.
1877.	67.	Under hospital treatment.
1878.	68.	Died in King's College Hospital. "Gouty kidneys."

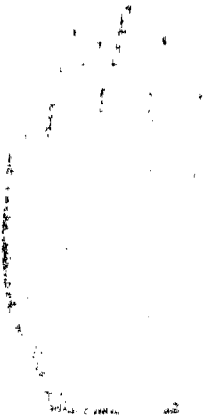


PLATE CXXXVII.

BULLOUS ERUPTION FROM FLEA-BITES.

In this Plate are shown the results of flea-bites on the arm and fore-arm of a fair-complexioned girl of 3 years old. There could be no dispute about the cause, for the offending insects had been seen and caught. The child was, during a year or two in early life, remarkably susceptible to the attacks of fleas, and they occasioned in her a very excessive amount of irritation. Several of her relatives had suffered in a similar way, more especially a grandmother and two of her cousins. Others (in particular a brother and sister) showed no special liability. The patient herself, now 16 years of age, has long ago ceased to suffer in the way that she did in early childhood. She is no longer liable to have vesications form, or to suffer any unusual amount of irritation.

The portrait shows, as is usual in such cases, various stages of the sores at the same time. The three most conspicuous spots were the result of pricks which had been received within twenty-four hours. As was then usual with the child, the pricks had caused bullæ as large as peas, and which were surrounded by a patch of florid congestion nearly an inch across. These bullæ were very delicate, and the eruption being extremely irritable, they were soon ruptured, with the result of leaving little superficial sores. The latter are seen in various stages on different parts of the arm. Their grouping is noteworthy, being wholly without regularity. They occur in lines, triangles, &c., but never in circles. To this linear and irregular distribution the term "constellation-like" has been not inappropriately applied. It is a characteristic of almost all eruptions which are due to the pricks of insects.

The reader will find some general remarks upon the eruptions due to insects at page 84, *et seq.*, in Fasciculus XVIII. It is there mentioned that in connection with the attacks of fleas very definite febrile symptoms, high temperatures, &c., are not unfrequently observed in children. In the case which is illustrated in this portrait, the disturbance of health was very definite, although not in high degree.

(From an original water-colour drawing by Burgess.)

"*Urticaria chronica infantium* (*Strophulus*)" in Jacobi's 'Atlas' is probably a representation of petechial flea-bites. No. 1 B, from Neisser's 'Clinik.'

E. Burgess del.

West, Newman chromo.

PLATE CXXXVIII.

PHTHYRIASIS PUBIS.

The conditions produced by the presence of lice on the pubic region are well shown in this plate. The hairs are covered with rows of eggs—"nits"—and at various places the parasites themselves are indistinctly visible adhering to the skin. This pediculus does not travel widely, but may often be met with in the armpits, and less frequently on the eyelashes. It does not infest the scalp. It causes the most intolerable itching, and very frequently excorrations, the result of scratching, attest its presence.

A mercurial ointment—Ungent Hydrarg. Fort.—is a very efficacious means of cure, and was formerly known as "Trooper's Ointment"; or the part may be shaved, and a milder white precipitate ointment applied.

E. Burgess del.

West, Newman chromo.

PLATE CXXXIX.

PITYRIASIS ROSEA.

In this Plate (which is taken from an original drawing by Miss Mabel Green) we have well represented the conditions present in the more common form of Pityriasis rosea. The patient was a young man who attended at the Clinic at Park Crescent. The eruption had been supposed to be syphilitic, but there was no history in corroboration of that suspicion. The subsequent history was that it faded away in the course of a few weeks, and no other symptoms followed. There remained, therefore, no doubt whatever as to the diagnosis. The lad was throughout in good health. The eruption had been out about three weeks before the portrait was taken, and, as usual, one patch had preceded all the rest by about a week. This parent patch is seen as still the most conspicuous one on the right side. The eruption was confined to the trunk and upper arms.

General Remarks.

The term Pityriasis rosea, or its equivalent, Gibert's Pityriasis, is applied to an eruption the recognition of which is of great importance on account of its close resemblance to some of specific origin. Mistakes in this direction have been very common, and have not unfrequently resulted in much injustice to individuals. The eruption is in all probability of cryptogamic origin; but, although several observers have supposed that they had identified the parasite, nothing has as yet been satisfactorily established. It is usual for the general eruption to be preceded by a single patch which is present alone for about a week before the blotches become general. To this patch the term "parent-patch," or "Brocq's patch," is given. The generalized eruption is usually completely out in the course of another week, and covers the trunk, back and front, and the upper parts of the arms and thighs, but avoids the face, fore-arms, and legs. The mode of its evolution is strongly suggestive of contagion, and consequently of cryptogamic origin; but, as already stated, the parasite has not yet been identified, and it is a very remarkable fact that no evidence as to the disease spreading in families has as yet been obtained. Pityriasis rosea is always met with in isolated cases, and generally in young adults, precisely under the conditions likely to excite suspicion as to syphilitic origin; yet there can be not the slightest doubt that it has nothing to do with specific disease. In many cases, after a few weeks' duration, it disappears spontaneously, or under treatment which can scarcely be considered to have been important. It has been supposed that the use of the sulphur bath hastens its disappearance, but it is only in exceptional cases that, even without treatment of any kind, the eruption lasts more than a few months. As a rule no relapses occur, and the skin is restored to a condition of perfect health. There are cases, however, in which slightly marked patches, either pigmented or very pale, persist without change for some years after the eruption.

There are two chief types of Pityriasis rosea: one in which the eruption shows well-margined slightly scaly patches, closely resembling those of common ringworm; and another in which the patches are not well margined, not scaly, and in which they suggest the blotches of a faintly marked roseola rather than ringworm. Between these two types there are all gradations, and the two are indeed often mixed in the same patient. The eruption is not usually attended by any irritation.

PLATE CXXXIX.—(*Continued.*)

Our older Atlases did not contain any delineations of this unimportant and yet very important eruption. It was first observed and described by Gibert, of the Hôpital St. Louis. An excellent portrait of it is given in Radcliffe-Crocker's 'Atlas.'

It seems possible that the eruptions to which this name is applied are much less common in Germany than they are in France and England. Kaposi's recent 'Hand Atlas' gives only one illustration (Tafel 101) of what is there called Herpes tonsurans maculosus. It is not at all a characteristic one of Pityriasis rosea; but from the more recently published 'Atlas' of Jacobi, we learn that this appellation is the one by which that malady is designated in Germany. It is much to be regretted that the Viennese school still persist in using the term "herpes" as equivalent to "tinea," since, in common with all other authorities, that school fully admits that these cryptogamic eruptions have nothing whatever in common with the herpetic group. As regards the association of Pityriasis rosea with the cryptogamic group, however, Jacobi goes the length of asserting that the malady is identical with ringworm, and that the fungus is present. He does not, however, state that he has ever found the fungus, and what he alleges is in such entire disaccord with the clinical facts, that we can only believe that he has not had opportunities of examining the disease, now so well known in France and England. His translator, Dr. Pringle, emphatically disavows his opinions; and M. Hallopeau, the distinguished author of the most recent French treatise, speaks of them as follows:—"Cette affection a été décrite par Gibert; elle constitue un type clinique des mieux caractérisés. L'école de Vienne la dénomme herpes tonsurans maculosus et la rattache à la trichophytie, bien à tort, car elle n'est ni herpétique, ni tonsurante; on n'y trouve pas le trichophyton et son évolution n'a rien de commun avec celle des trichophytons."

Mabel Green del.

West, Newman chromo.

PLATE CXL.

TINEA TONSURANS ON THE CHEST OF AN ADULT.

The conditions which are delineated in this Plate and in the one next to follow are those which were displayed by a lady about 35 years of age, who had been for some months engaged in dressing her children's heads for common ringworm. At length she developed patches of ringworm on her own neck, and these coalesced and spread by a continuous border over her shoulders and chest. The eruption had been slowly advancing for several months when the portrait was taken. The fungus was found abundantly in epithelial scales scraped from the margins of the patches, and the eruption was subsequently quickly cured by the use of a weak chrysophanic ointment.

These portraits well illustrate the fact that the ringworm cryptogam is not, for the most part, able to maintain itself long on any part of the adult skin. The surfaces originally attacked are seen to have been restored to health, whilst the invasion of others is still in active progress. Exceptions to this law of spontaneous decline may be encountered in certain special regions, as in those often affected by what is called "eczema marginatum," where the moisture, &c., of the parts favours its perpetuation. On the naked skin, however, and where no folds come into apposition, it is certainly the rule that the fungus quickly exhausts its soil, and that it shows little or no tendency to infect the follicles. Nor does it as a rule show much activity in affecting parts of the skin not in continuity with the original patch. It is exceptional to see a generalized eruption. These Plates well illustrate this remark, for the patches have continued to spread at their margins, whilst none have been produced at a distance from them.

It is quite possible that recurrences may, after a time, take place in the area which has been left behind, and in the present instance patches are seen at the root of the neck in Plate CXL., in which either the disease has recurred, or has never been wholly extinguished. On the broad belt which is involved in the middle of the chest, it is to be observed that the activity of the disease is obviously greatest at its aggressive edge, which is slightly raised and minutely lichenoid. The upper parts are paler, irregular in outline, and obviously in process of breaking up. The bilateral symmetry is remarkably exact, and in this we have a good instance in proof that such symmetry does not always imply blood infection. It may, as is here shown, occur in connection with a cause which is entirely external.

Mabel Green, del.

West, Newman chromo.

PLATE CXLI.

TINEA TONSURANS ON THE BACK OF AN ADULT.

This Plate exhibits the back of the same patient whose chest is represented in the previous Plate. The ringworm had spread from the root of the neck, and was still advancing downwards.

Mabel Green del.

West, Newman chromo.

PLATE CXLII.

LICHEN SCROPHULOSORUM.

This Plate gives a very accurate representation of the conditions produced in an ordinary and slight form of the disease above named. The drawing from which it is reproduced was exhibited at the International Congress of Dermatologists in London in 1897, and was recognized at a glance by all skilled observers who saw it. The patient was a delicate little boy, whose father had died of chest disease, and whose brother subsequently suffered from enlargement of the cervical glands. The boy recovered from his eruption in the course of about a year, and at the present time—eight years later—is quite free from it. He is at present in very fair health, having had the advantage of residence at the seaside, and of every home-care which could be given.

Lichen Scrofulosorum in the form which is here delineated is a mild disease, and generally disappears after a few months' duration. It consists of little groups of minute lichenoid papules of a light brownish tint, and not attended by any material congestion of the skin in which they are placed. They render the skin a little rough, and are distinctly perceptible to the touch. They are not usually attended by any material irritation, and seldom show any results indicative of scratching. Although rarely encountered in those who are at the time suffering from pulmonary or other form of visceral tuberculosis, they are almost always met with in association with a clear history of such affections in relatives, and are not infrequenly attended by other manifestations of what may be called "scrofula" in the individual. Thus there may be an enlargement of lymphatic glands, sycosis of the eyelashes, or possibly lupus vulgaris. Continental authorities have recognized beyond dispute the tubercle bacillus in the papules, and some have even ventured to name the disease "Miliary tuberculosis of the skin." Our illustration represents the commonest and the mildest type of the disease. We owe to Hebra the original description of it, and both his descriptions and his plates exhibited a much more widely spread and severe affection than is here shown.

Radcliffe Crocker, in Plate XXXIV. of his 'Atlas,' has a excellent portrait of the disease.

Dr. Tilbury Fox had written of it, and given portraits, under the name of "Cacatrophia folliculorum"; and Kaposi's 'Hand-Atlas' has a series of instructive portraits. Some of these latter show the disease in very extreme forms, but unfortunately they are rather roughly executed, and wholly without clinical histories.

In Jacobi's 'Atlas' the portrait of Lichen Scrophulosorum shows the eruption on the back of a delicate boy, who had a flat chest, enlarged glands, and phlyctenular conjunctivitis, and who was suspected of pulmonary disease. The diagnosis given is that of "*Tuberculosis Milio-papulosa aggregati.*"

CORRESPONDENCE, ADDENDA, &c.

It is intended to give in this page (which will be repeated as may seem desirable) any notes which may be obtained in completion of any of the cases which have been illustrated; answers to questions asked; additions to statements; and, when needful, corrections of errors. The Editors will be much obliged to any of the Society's members who may be able to add particulars as to the sequel of cases, or to give information respecting them. The importance of making all clinical records complete cannot be overrated.

Purpura urticans is a name very appropriate to ecchymotic insect-pricks (flea-bites, &c.). Probably it has never been applied to any other conditions, for when purpura is of blood origin it is not attended by irritation.

Distinction between Flea-bites and Petechiæ.—In addition to the statements already made, the following may be of interest:—

In Dr. Tilbury Fox's 'Atlas,' Plate 44, representations are given of petechiæ and flea-bites. The text states that "they are intended to show the relative characters of petechiæ and flea-bites, the latter being distinguished by a central puncture, which remains under pressure while the surrounding redness disappears."

It is not possible, in the Plate given, to make the slightest distinction between the two. They might be taken to represent the same condition, and a sceptic may be excused the suggestion that in all probability both do represent flea-bites.

The presence of a central puncture, although in many cases very useful as a means of diagnosis, is by no means invariable. In the majority of cases of insect-pricks all evidence of the puncture has vanished within twenty-four hours. Nor is it quite true that the redness will always disappear, for ecchymosis is often present.

The case described and figured by Willis as "Urticaria petechialis" has a history very much like that of bites, and was possibly of that nature. He referred to it as being the same as that described by Willan as "Purpura urticans," but asserts strongly that it has no feature in common with Purpura. He speaks of the formation during the night of wheals of the skin or more considerable swellings, involving both the skin and cellular tissue, and these succeeded on the morrow by one or more bright red spots, which passed through various shades of colour as they vanished. He states that his patient (a girl of twelve) appeared to be in excellent health, and that the eruption disappeared, and did not recur.

Corrections of numbering of Plates.—Some of our subscribers may have noticed that in Fasciculus No. XVIII. several Plates have numbers which do not correspond with those given on the descriptive letterpress. It is the latter which is correct, and it will be well for their possessors to alter in ink or pencil the number given in top right-hand corner of the Plates themselves. Plate CXLI. should be CXVIII.; Plate CXLII. should be CXIX.; Plate CXLIV. should be CXX.; and Plate CXLIII. should be CXXI. In all instances the Plate and the descriptive letterpress are correctly placed together; it is the lettering only which is wrong.

Completion of Case 6 given at page 76.—The patient who supplied Portraits CVI. and CVII. has since their publication died. He was the subject of *Arsenical Cancer*. His death was due to exhaustion from a large fungating growth on the left shoulder, and there were also symptoms of implication of the lungs. He had many spots and patches tending towards the cancerous process on various parts of the surface, face, limbs, &c. Some of these were papillary, but the majority in a condition of exfoliative keratosis. The whole duration of his case was about five years. Details of microscopic examination are given at page 76. It is Case 6. Of the growth on the hand, the report was "squamous-celled epithelioma; and of a subcutaneous growth on right shoulder, soft carcinoma of the acinous type" (Mr. Targett). The case is therefore of great importance as proving that the use of arsenic may give proclivity to different forms of malignant neoplasm, and that its influence is not restricted to the skin.

(*Correspondence, Addenda, &c., continued overleaf.*)

Insect-bites.—A correspondent questions whether it is more correct to speak of "insect-bites" or of "insect-pricks." It does not perhaps much matter, and the one expression comes as near to the actual fact as the other. Wounds inflicted by the mouth and proboscis must, however, always be clearly distinguished from stings, and these latter are perhaps more correctly called pricks. The ovipositor of the insects which prick in order to deposit eggs is analogous to a sting. The bite of a flea or mosquito is a wholly different procedure, and we are so accustomed to speak of "flea-bites," "bug-bites," &c., that it seems a pity to attempt any change of the expression. All the blood-sucking insects have a proboscis adapted for sucking, in the interior of which organ are lancets or setæ for piercing. Thus they prick the skin of the animal (or bark or leaf of a vegetable), and then insert the proboscis into the wound. The proboscis and its setæ are modifications of the lower mandible and of the labrum, and thus it is after all not a great blunder to speak of them as "biting." They certainly do not, as one author has imagined, insert their suctorial proboscis into a follicle without causing breach of surface.

Yaws.—Dr. Ozzard, writing in the 1904 number of the 'British Guiana Medical Annual,' says:—"Yaws is very common in certain districts. . . . . Syphilis is also extremely rife all over the colony, and without doubt it is at times hard to say whether a particular case should be called syphilis or yaws." The contention in Fasciculus XIV. (in which Yaws is very fully illustrated) was that Sydenham was right in considering that yaws is simply syphilis with a frambœsial eruption.

AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY

AND

PATHOLOGY

(CHIEFLY FROM ORIGINAL SOURCES).

FASCICULUS XXII., OR XIV. OF NEW SERIES.

LEUCODERMA.

PLATES A to H.

MYXŒDEMA.

PLATES I and J.

MISCELLANEOUS.

PLATES K to O.

ERUPTIONS CAUSED BY DRUGS.

PLATES CXLIII. and CXLIV.

LONDON:
THE NEW SYDENHAM SOCIETY.
1905.

LEUCODERMA.

Some General Statements.

Under the name Leucoderma we now recognize a condition in which portions of the skin have lost their pigment and become white. The patches, small at first, spread at their borders, but always remain more or less rounded. It was formerly known as Vitiligo or Leuce, and was often confused with true Leprosy.

That the pigment of the human skin varies in quantity and in tint in different races, and in the same race in different regions of the globe, and in the same person under different conditions as to health and exposure, are facts well known to all. That as a congenital and heritable state there may be a more or less complete failure of pigmentation is familiar to the students of Albinism. In the phenomena of Lentigo, or common Freckles, in those of Xeroderma pigmentosum (or perhaps better, Lentigo maligna juvenilis), and those of Addison's disease, we have examples of excess in pigment-accumulation passing in some instances beyond the limits of physiological variation, and assuming the characters of disease. In none of these, however, have we any counterpart of what is observed in the affection known as Leucoderma. In them the pigment-increase occurs either diffusedly in large areas of skin with perfect bilateral symmetry, or it is arranged, as in freckles, in ill-margined accumulations, in relation, no doubt, with anatomical peculiarities of structure. In Leucoderma, on the contrary, the whitened skin occurs in definite patches, which are well margined, and are aggressive. They may prove aggressive to such an extent that the entire surface may become finally involved, and the whole skin completely decolorized. This mode of aggression is obviously very different from that observed in Addison's disease, the result being in the one diffuse bronzing, and in the other a piebald state. No condition resembling Leucoderma has as yet been recorded as occurring in the lower animals. Their piebald or parti-coloured hides are congenital, and make no changes after birth, and in the process by which arctic animals change their brown summer-garb for the white one of winter, there is only an imperfect approach to the patched or really piebald stage. Leucoderma therefore stands by itself as a distinctly pathological result, upon which nothing that is known as to physiological processes throws much light.

Is it of Local or Constitutional Origin?

There are several facts in the history of Leucoderma which would lead to the suspicion that the changes take their origin in the skin itself rather than in the blood. In addition to its mode of spreading, just adverted to, we have the circumstance that it is seldom possible to detect any deviation from good health in those who suffer from it. Its persistence and steady advance through many years is not attended by any failure of strength. In a few cases in English practice Leucoderma has been observed to be co-existent with debility and cachexia. They are not, however, sufficiently numerous to entitle them to rank as more than mere coincidences. Amongst fair-complexioned and white-skinned populations very probably there are many subjects of Leucoderma who never take any notice of the change, and who certainly never think it worth while to seek advice. It is to be expected that now and then one of these, having fallen out of health, and having been undressed for professional inspection, may supply an example of the coincident occurrence referred to. In hot countries, and amongst those whose darkness of skin renders the condition very conspicuous—and its

examples accordingly seemingly common—no such connection has ever been noted.

Age and Sex.

Leucoderma is never congenital, and rarely begins in very early childhood.* The age of the youngest patient on record was four years (Radcliffe Crocker), and from that age onwards to middle life it is fairly common. It becomes more rare again as senility advances. In most of the cases on record, and especially those of which portraits have been preserved, it had had its commencement some years prior to the date of observation. As to Sex, there is no reason to believe that it exercises any influence.

Its Nature and Alliances.

Since we are confessedly ignorant of its cause, it may perhaps seem useless to attempt conjectures as to its nature; but the subject is of such great interest that it is impossible to leave it wholly aside. Certain negative facts seem fairly well established. It does not depend upon any failure in general health, nor does it lead to it.

Some facts might be supposed to support the creed that those in whom pigmentation is easily excited by exposure to sun, &c., are especially liable to Leucoderma. Here again, however, we have the fallacy that it is precisely in such that the white patches most easily attract attention. All leucodermic patients, especially those in whom the face or hands are affected, think their condition worse in summer and when at the seaside. The explanation is, of course, that then the contrast becomes greater owing to the physiological hyper-pigmentation of the unaffected skin.

Its Relation to the Disease known as "Pinta."

In connection with Plates D and E, it is pointed out that a graphic illustration which has been published in the English translation of Scheube's excellent work on the Diseases of Hot Countries, really shows only a good example of Leucoderma. It seems not improbable that, in the descriptions of Pinta which have reached us, a cryptogamic eruption closely allied to Tinea versicolor has been mixed up with examples of Leucoderma. That not all the cases belong to the latter is made certain by the description of the varying tints of the patches—"pale grey to black, blue, red, or white"—and by Gastambide's observations on the fungus which he found present. Few, however, will entertain any doubts as to the nature of the case figured in our Plate. Probably no good photographs of the cryptogamic Pinta have as yet reached England.

Comparative Prevalence in different Races.

Statistics would appear to give a most definite support to the impression of all observers as to the comparative rarity of Leucoderma in fair-skinned communities. It is believed to be far more common in India and Africa than in England. There is, however, a fallacy, which it is impossible to eliminate, in the fact that in English practice but a very small proportion of the cases ever come under medical observation. It is a life-long affection, and thus in countries where the native hue makes it a conspicuous condition, its supposed prevalence may easily be exaggerated. The same patient may come under the notice of different observers. It is quite certain that it is essentially the same malady in all countries, and that it is met with in all. Race appears to exercise but little influence. In English practice it would seem to be much more common in those of dark complexion than in the fair. Here again, however, the fallacy just referred to comes into play. It is conspicuous only in dark persons. It is, however, obvious that it could not occur in an albino, and the suggestion may be accepted as probable (though by no means proved) that the liability to it decreases in ratio with the decrease of pigmentation in the individual. Curiously, there appears to be but little evidence that Leucoderma is common in negroes. Its supposed frequency occurs in deeply pigmented members of white-skinned races.

* Several cases are mentioned in 'Archives of Surgery' in which the changes were believed by the parents of the patient to have begun almost in infancy. In one the evidence seemed satisfactory for the age of two years, and in another for three (vol. i. p. 379).

Is there a preceding Stage of Melanoderma?

When a Leucoderma patient is undressed for inspection, there very frequently arises some dispute as to whether or not the portions of skin retaining pigment are abnormally deep in tint. The patients themselves almost invariably insist that they are so, and in many cases medical advice has been sought in the belief that the skin was becoming dark. This question can, of course, occur only in white-skinned persons, for amongst the dark races there can never be any doubt. In English practice, however, the contrast between the whitened patch and the rest is often so great that at first sight it is almost impossible not to suspect abnormal pigmentation. This contrast has led some to suggest that a general melasmic change is often the first stage of the disease, whilst others have supposed that the pigment is driven out of the bleached areas, and accumulates at their margins.

Patients themselves are firmly convinced that their skins never before were so dark as they must now appear to have been if we accept the unchanged portions as normal. There can be no doubt that in most instances an illusion is produced by the strong contrast which the paper-white patches offer to the ground on which they are placed. This may usually be convincingly demonstrated if the patches are covered up with brown paper. In a few instances, however, it is to be admitted that the boundaries of the patches show a deeper tint than the rest of the skin. This, however, is but exceptionally well marked, and is usually quite absent. None of the photographs which we now publish exhibit it.

As regards diffuse pigmentation, it is possible that in certain cases such a stage does precede the areate bleaching, but there can be no doubt that in the majority there is no proof of it.*

It is of interest to note that this asserted accumulation of pigment at the borders of the patches is not shown in the best coloured portraits of Leucoderma which have been published. There is not the slightest trace of it in Radcliffe Crocker's portrait, nor in those of Kaposi (T. 155 and 156). It is shown in places in that given in Vol. I. of the London Hospital Reports, but in that instance it was not noticed when the patient was under observation.

Rate of Progress, &c.

The patient from whom the portrait published in Vol. I. of the London Hospital Reports was taken, was first observed in 1862. He was seen again two years later, and for a third time a few years later still, and on each occasion the portrait was produced for comparison. His patches during these intervals had changed exceedingly little, none had disappeared, and but little enlargement or change of contour was observable.

In another case, in which a photograph was taken in June, 1876, the patient (a woman) was seen again sixteen years later, and her state carefully compared with the portrait. The patient had become less dark but more ruddy, and the contrast between the patches and the rest of the skin was now so slight that they might easily have escaped observation. On careful inspection, however, some of the patches were seen to be of exactly the same size and contour as those shown in the photograph; others were much less distinct than formerly.

Prognosis and Treatment.

Accurate observations are much to be desired as to the sequel of cases of Leucoderma. For the most part we have but fragments of cases. In several instances it has been proved that the patches have in the course of many years undergone little alteration either in extension or the reverse. In a few they have extended so as to involve the entire surface. The records of recovery are perhaps not beyond suspicion, and all such statements ought to be corroborated by photographs. The affection is, indeed, one which lends itself

* An instructive narrative bearing upon this point will be found in 'Archives,' vol. i. p. 377. The subject of the Leucoderma was a young lady. Her skin was as dark as that of a Mulatto, and at first it was thought that she must be the subject of Melanoderma. She, however, produced her mother, who was in perfect health, but who had a skin just as dark as her own.

easily to the photographer's art, and our knowledge of it has already been much helped by it. We may hope in the future for great advance in the exactitude of our statements if those who have the opportunities will diligently make use of them. In the meantime, it seems probable that most of the cases show a very gradual advance, and that their progress is not obviously influenced by treatment. The patient may look forward either to the condition becoming stationary, or to its gradual extension. Until we are in possession of data enabling us to estimate more accurately the course taken in cases not interfered with, we cannot form satisfactory opinions as to the results of treatment. It may be that courses of arsenic tend to influence the progress of Leucoderma as they do those of Pemphigus and Psoriasis, but we cannot feel sure of it. Chrysophanic acid ointments are also well worth trial.

Diagnosis.

The abrupt margins, rounded borders, and dead white aspect of the patches, taken together with the fact that there is entire absence of thickening, congestion or desquamation, usually make the diagnosis of Leucoderma easy.* Mistakes are, however, very frequently made. In Leprosy-countries it is frequently mistaken for that disease, and in English practice Addison's Disease may be suspected, or the patches may be confused with those of Morphœa. In some instances, it is true, the patches of Maculo-anæsthetic Leprosy are exceedingly like those of Leucoderma, and, although some degree of Anæsthesia usually attends them, it is not invariable.† Such patches are, however, seldom really white, and often they are not absolutely smooth like those of Leucoderma. Other symptoms are also usually present, denoting the more formidable malady. It is very probable that in all ages up to quite recent times Leucoderma has been accounted a form of Leprosy. The expression "a leper white as snow" was probably applied to Leucoderma, for, as just stated, true Leprosy is seldom really and extensively white. In India, almost up to the present time, the statistics of Leprosy have been falsified by the inclusion of many cases of Leucoderma.

From Addison's Disease the diagnosis may be easily made by observing the arrangement, form, and definiteness of the patches. That it is the white and not the dark which is advancing may always be made certain by observing the borders of the patches. These are rounded, and if by coalescence they have become irregular, they still present crescents, and have the yet pigmented skin projecting as little promontories. In Addison's Disease, although there may be parts of the surface which are dark, and others pale, none are really white, and there are no abrupt margins.

It has nothing to do with Syphilis, nor is it a sequel to any form of cryptogamic disease. It is not contagious, not conspicuously heritable, nor is it usually seen in more than one member of a family. It is impossible not to be struck with the fact that most of these statements are just what may be asserted of common Psoriasis. When it is added that both these affections begin by the formation of small patches of rounded outline, which advance at their borders, may coalesce, and may eventually cover almost the whole surface, the parallel becomes yet more striking. If, indeed, the patches of Leucoderma had scale-crusts, there would be little or no distinction to be traced between the two. In both imperfect or non-aggressive forms are common,‡ and in both the aggression is sometimes such that the entire surface is involved.

Is it possibly a Survival of Leprosy?

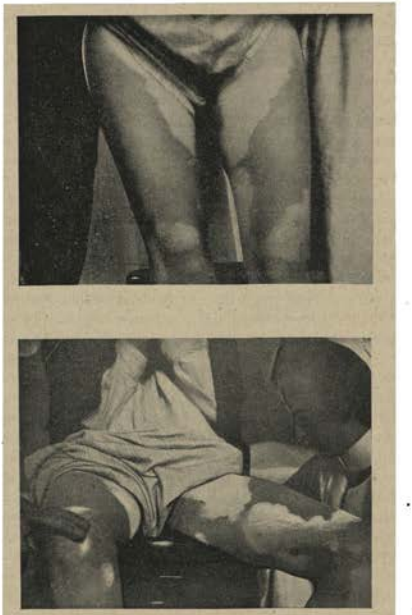
A fact of much interest in reference to Leucoderma, and perhaps one of much importance as offering some clue to a knowledge

* See a lecture on the diagnosis between Leucoderma and white Leprosy, 'Lectures on Clinical Surgery,' vol. i. p. 33.

† See Plate H, and compare with Plate C.

‡ In 'Archives of Surgery,' vol. i. p. 370, occurs the following remark: "This case supports the hypothesis that Leucoderma belongs to the Psoriasis group. If the patches were scaly instead of being merely blanched, it would be Psoriasis. They began on the fronts of knees, are symmetrical, have slowly increased, and in no way interfere with health."

of its nature, is, that it may be very closely simulated in the course of Leprosy. The ordinary forms of Leucoderma, although in former days often mistaken for Leprosy, have certainly nothing in common with it as regards essentials. That decolorization of the skin in patches may, however, occur in true Leprosy is most unquestionable. Nor are the conditions under which the white patches are produced and spread at their borders in any respect different from those observed in common Leucoderma. Let the reader make careful comparison of the figures in Plate C with the lower portrait in Plate H,



Leucoderma simulating Leprosy.

These two figures are reproduced from photographs kindly supplied by Dr. Russell, of Lincoln. The patient was an Englishman. The contrast between the light and dark areas is very marked. In order to appreciate the simulation of Leprosy, the reader should refer to Fasciculus XVIII., Plate CXXIII.

and of the two in the latter with one another, and he will be convinced of this. The two given in Plate H are almost exact repetitions of each other so far as arrangement and form of patches is concerned; yet the one is from an English boy, the subject of Leucoderma, and the other from a Hindoo suffering from Leprosy. If, again, the conditions shown in the figures here given be contrasted with those exhibited in Plate

CXXIII. of Fasciculus XVIII., the resemblance will be seen to be most striking. In both, abruptly margined, round patches of white are seen upon a dark ground, and in both the patches are aggressive and threaten to decolorize the whole surface. It may be admitted that in Leprosy the patches are seldom so absolutely white as they usually are in Leucoderma, and that not unfrequently they are not quite smooth, nor do they often occur on the face. These, however, are minor points, and in their main features the resemblance is close. In Leprosy there is usually, but not invariably, defective sensation in the bleached areas, whilst in Leucoderma the loss of colour stands alone. This is undoubtedly the chief and most important distinction.

Leucodermic changes occur in Leprosy in three principal forms. In some a single pale or white patch is the first symptom which is observed, and is often for a certain time solitary. In others dark patches or large indefinite areas are the first condition, and in the middle of them others are developed. In these the brown is sensitive, and the white much less so. Lastly, a condition of scattered white patches arranged with fair bilateral symmetry may be the first symptom. These are the cases which most nearly simulate common Leucoderma, and of which the portrait given in Plate H affords a good example.

In explanation of these several conditions it may be suggested as probable that in all cases of Leprosy the earliest stage is one of diffuse and generalized Erythema. This is in some cases conspicuous and definite, being attended by œdema and some dusky discoloration. In others, however, it is so slight that it is quite overlooked. It is upon skin thus affected, and as yet not defective in sensation, that the white anæsthetic patches are, as a secondary change, produced.

It is in the maculo-anæsthetic type of Leprosy that leucodermic changes usually occur, and in this form the presence in the skin of Hansen's bacillus can but very rarely be demonstrated, the inference being that the changes witnessed are the result rather of the toxine than of the parasite itself. It is certainly a very unexpected fact that either the one or the other should be capable of causing loss of pigment in patches which spread by a sort of "contagion by continuity" at their borders. A conjecture which will probably occur to many who take cognizance of the facts now stated is that, after all, Leucoderma, as we now observe it, is in some sort a survival of Leprosy. That it is caused by the presence of the Leprosy bacillus no one will suggest, but it may possibly be due to some inherited tendency on the part of the skin itself which had its origin in leprosic erythema. It is undoubted that the two are often met with in the same communities, and that in those in which Leucoderma alone occurs there is the history of Leprosy in former generations. We must not, however, venture too far into the regions of transcendental pathogenesis, but be content for the present to draw attention to very remarkable facts.

LEUCODERMA.

PLATE A.—Leucoderma—The face of a dark-skinned man (Roumanian).

" B. " The face of a woman of dark skin (Roumanian).

" C. " In a Mulatto. / In a fair-skinned English boy.

" D. " In a woman, the supposed subject of "Pinta."

" E. " Back view of same.

" F. " Two portraits of a man in whom it became universal.

" G. " Face and arms of a woman. / The hands in neuritic Leprosy.

" H. " The trunk, &c., of an English boy. / The Leucoderma of Leprosy in Hindoo.

PLATE A.

THE FACE OF A MAN WITH LEUCODERMA.

This portrait, copied from one published by Dr. Münch, shows the arrangement of leucodermic patches on the face of a very dark-complexioned man. Patches, arranged almost symmetrically, are seen on the cheeks, the changes having, however, made most progress on the right side. The beard is almost wholly white, but there is a central pigmented patch in middle of chin.

In a few parts the borders of the parts still retaining colour are undoubtedly more deeply pigmented than the rest, but in most no such increase can be observed.

As an example of bilateral symmetry, with unequal rate of progress on the two sides, the portrait is of much interest. The right supra-orbital region has lost all pigment, and the right side of nose, with the exception of a few remaining dots. The large cheek-patch is of almost exactly the same form on the two sides, but on the right is much paler than on left, and is reduced at its upper and inner parts.

PLATE B.

LEUCODERMA IN A DARK-SKINNED WOMAN.

The portrait of a very dark-complexioned woman taken, like the preceding, from Dr. Münch's work. It is remarkably like the preceding one, but with yet more definite illustration of bilateral symmetry. Again, however, the changes are slightly more advanced on the right than on the left side. There is in this instance little or no evidence of deepening of tint in the margins of the patches still retaining pigment.

PLATE C.

LEUCODERMA IN A MULATTO, AND IN AN ENGLISH BOY.

The illustrations given in this Plate have been placed together in order to exhibit in effective contrast the different aspect of leucodermic changes when occurring on the skin of a mulatto, and on that of an English boy. In each instance the removal of pigment on certain areas has been complete, and it is worthy of remark that in each case almost precisely identical areas are involved. Yet how great is the contrast. In the case of the boy the changes might easily be overlooked, whilst in that of the mulatto the piebald condition is grotesquely conspicuous. It may be realized, from looking at these photographs, that Leucoderma in the dark races, being open to the observation of all, may easily have its relative prevalence over-estimated, whilst amongst the inhabitants of northern latitudes it may be often overlooked.

As regards the arrangement, it may be observed that the neck in both is blanched, and that in both a considerable area above and below the umbilicus retains its pigment. In both the fronts of the thighs are white up to the fold of the groin, and in both an irregular area of white passes up the middle of the lower part of the back. This similarity of arrangement may have been accidental to some extent, and certainly it is by no means exactly followed in some other cases. (See Plates D, E, G, and H.). In Plate D precisely the fronts of the thighs here made white are there left dark, whilst the lower abdominal region is blanched.

Bilateral symmetry, not exact, but still definite, may be traced not only in these, but in most of the other Plates now given.

It may be noted with interest that there is no indication in the case of the boy of deepening of tint in the unaffected parts, nor in either of them of any accumulation of pigment at the margins of the patches.

The boy was under the care of Dr. Lowe, of Ludlow, by whom the photograph was supplied in 1885. He was then ten years old.

The mulatto man was a native of New Albany, Indiana, and was past middle age.

PLATE D.

LEUCODERMA IN A NATIVE OF SOUTH AMERICA.

The portraits given in this Plate and the following one are from photographs executed for Dr. P. G. Edgar.

They are of especial interest because they have already been published as illustrations of a disease known as "Pinta" in certain tropical parts of the Western Hemisphere. Contrasting them with the other portraits now given, there will probably be no hesitation in assigning them to Leucoderma.

It may be remarked that in this instance the bilateral symmetry of leucodermic changes is well illustrated. There are some remarkable differences as well as some resemblances in the arrangement of the patches as compared with those in the Mulatto figured in Plate C. There is no evidence of deepening of tint at the margins of the patches.

It is in the English translation of Scheube's work, 'The Diseases of Warm Countries,' that these two portraits are adduced as illustrations of "Pinta." They do not occur in the original. Scheube himself defines "Pinta" as "a dermato-mycosis," and most of its examples are probably closely allied to, if not identical with, Tinea versicolor. It is likely enough, however, that examples of Leucoderma are sometimes so diagnosed. Its various names imply a piebald appearance, "Mal pintado," "Spotted disease of South America," &c.; and Scheube states that the disfigurement often "reminds one of a painted circus clown." Its cryptogamic nature has been proved by Dr. Gastambide's researches. It is for future investigations to show in what it differs from Tinea versicolor, and in the meantime Leucoderma is to be carefully distinguished from it.

PLATE E.

LEUCODERMA IN A NATIVE OF SOUTH AMERICA.

This Plate gives the back view of the same patient as in the previous Plate. It is to be again observed that there is not the slightest indication of deeper pigmentation of the parts adjacent to the white patches.

PLATE F.

LEUCODERMA INVOLVING THE ENTIRE SURFACE.

The case here illustrated was published by A. A. Hamilton, M.B., B.Ch. Dubl., of Adelaide, S.A., by whom the patient had been shown at a meeting of the South Australian Branch of the British Medical Association at Adelaide, on 28th May, 1896. The following were the particulars then given:—

"S. G., æt. 42, cook, male Goanese-Portuguese by birth; father, pure Goanese; mother, half-Goanese, and half either French or European-Portuguese. Up to the age of 36 the patient was of the ordinary dark copper colour of his race. Then, about 1890, whitish patches began to appear on his right temple, which increased in size till, when he came under my observation in 1895, his entire body was white, with the exception of some dark patches on the axillæ, and dark spots along the border of each auricle. Now (June, 1896) the latter spots have almost disappeared; the skin itself is soft and healthy, though of a bleached, unnatural whiteness. There is no history of injury at the place where the loss of pigment began, nor is there any impairment of the senses of taste and smell; the patient is in very indifferent health, suffering from chronic rheumatism, with frequent subacute exacerbations. He also complains of increasing debility, and of feeling the cold weather severely. His hair has become grey during the time that the loss of pigment has been going on in the skin. The case is interesting, not only from the completeness of the metamorphosis, but also from the short time—*viz.* about five years—in which it occurred. In the few recorded cases to which I have access the change seems to have taken a much longer time. S. G. was cook in the Adelaide Hospital before his colour began to change, and is well known to many who were then, and are still, connected with that institution."

It will be observed that some irregular patches of pigment still remain in the man's axillæ. The shapes assumed by these prove that they are relics left by an invasion-process.

Two years ago a man was shown to the writer when in Ceylon by the Hon. Dr. Rockwood, of Colombo, in whom the removal of pigment was quite complete. The patient was a Cingalese; he had become quite white, and might have been taken for a very pale European. He was in good health, though past middle age. The change was believed to have occupied six or seven years. Leucoderma is common in Ceylon.

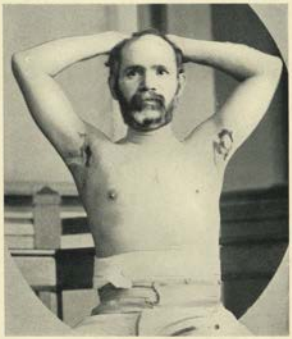


PLATE G.

FIG. 1.—LEUCODERMA IN A WOMAN OF MIXED RACE.
FIG. 2.—THE HAND IN NEURITIC TYPE OF LEPROSY.

FIG. 1.—This portrait supplies a very striking illustration of the contrast between the completely decolorized skin and the parts not yet involved. The patient was a woman of mixed race, and of a very dark skin. It may be pointed out that the patches are arranged with fair bilateral symmetry, the central parts of the face having been left dark, like a domino or half-mask. On the arms only little islands of pigmented skin have been left. It is evident that the patient was in a fair way to become entirely white.

FIG. 2.—The hand here shown is given as an excellent illustration of the conditions which attend the neuritis of Leprosy. The hand is that of the patient whose leucodermic changes are shown in the next Plate. Our object in producing the hand is to clinch the diagnosis of Leprosy, as otherwise the skin conditions might possibly have been assumed to be those only of Leucoderma.

The wasting of all the small muscles of the hand is well shown, the digits being all flexed towards the palm, and the latter presenting a saucer-like concavity. As usual, the little and ring fingers are more flexed than the others, the ulnar nerve being the first to suffer.

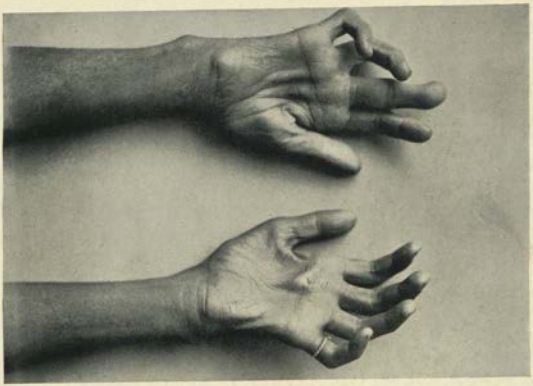


PLATE H.

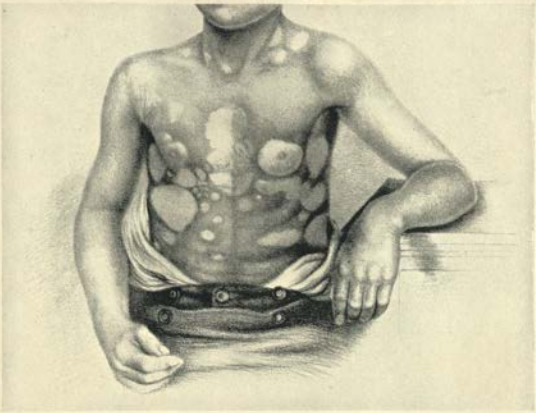
FIG. 1.—LEUCODERMA IN AN ENGLISH BOY SIMULATING LEPROSY.
FIG. 2.—MACULO-ANÆSTHETIC LEPROSY IN A HINDOO SIMULATING LEUCODERMA.

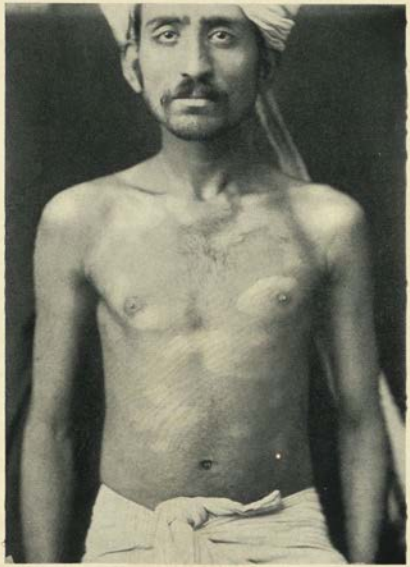
The upper portrait in this Plate is copied, with the omission of colour, from the illustration of Leucoderma given in vol. i. of the London Hospital Reports. Its subject was a dark-complexioned boy of English parentage, and in good health. The lower figure is that of a Hindoo leper.

In Plate G, given in Fasciculus XX., the conditions present in a severe case of what is styled tuberous leprosy are exceedingly well shown; the whole face and both hands and feet being greatly swollen and covered with ulcers. In that form the stress of the malady falls upon the skin itself, and bacilli are present in enormous numbers. The nerves suffer comparatively little, paralysis is often entirely absent, and the patient is still able to use his much ulcerated limbs. In strong contrast is the one which we now offer. It is from a photograph which has just been received from Dr. Sutherland, Professor of Medicine in the Medical College at Lahore. It shows in very typical form the conditions which are so frequently present in what is known as the maculo-anæsthetic form of the malady. In this form the nerve trunks always suffer. The skin is extensively affected, but without the production of any degree of œdema, or anything in the least approaching to tuberous swelling.

The patches are numerous and white, and differ chiefly from those of Leucoderma in the fact that they are more or less anæsthetic. It is probable, however, that there is always a diffuse condition of general discoloration and slight œdema which precedes the formation of the white anæsthetic patches. These patches are to be regarded as resulting from a slight form of dermato-neuritis affecting, and often destroying, the terminal sensory structures. They are in no relation with the distribution of nerve-filaments, and are to be regarded as having originated in local changes. They are, however, in almost constant association with neuritis of the nerve-trunks, and with muscular paralyses consequent therefrom. In this instance the hands of the patient well illustrate this association. It will be seen that the ulnar fingers are bent, and that the small muscles of the hand, more especially those supplied by the ulnar nerve, are atrophied. (See preceding Plate.)

Our object in presenting this Plate in its present association is not so much to illustrate Leprosy as to exhibit the very close resemblance to common Leucoderma which is sometimes produced by that disease. No doubt as to diagnosis can be felt, for not only is the state of the hands conclusive, but Dr. Sutherland's notes record that the white patches had to some extent lost sensation. But for this confirmation it might have been suggested that, after all, we have only an instance of the occurrence of Leucoderma in a patient who was suffering from Leprosy. There can, however, be no reasonable doubt that the leucodermic patches are really part of the leprosic changes. If the reader will turn back to Plate C, and will also carefully compare the two given in the present Plate one with the other, he will observe that the conditions displayed in all three are precisely alike. Yet two of them represent English boys who were quite free from Leprosy. The subject is fully discussed at page 17.





ILLUSTRATIONS OF MYXŒDEMA.

PLATE I.—Myxœdema in an early stage.
„ J.—Myxœdema in successive stages.

PLATE I.

MYXŒDEMA IN AN EARLY STAGE.

This portrait is a reproduction from a photograph, and well illustrates the sad and sleepy aspect of an early stage of Myxœdema. The patient, a woman of 30, was brought to the Polyclinic at a recent meeting by Mr. G. W. Sequeira. She has much improved under treatment.

In place of any description of the symptoms in this individual case, it may interest our readers to have, from the pen of one of the original discoverers of the malady, the latest summary of those which are usual. The following description is taken from the Bradshaw Lecture delivered by the late Dr. Ord before the College of Physicians, November, 1898:—

The Symptoms of Myxœdema. By W. W. ORD, M.D., F.R.C.P.

"Let us now endeavour to make a classified list of the signs and symptoms of Myxœdema. The first lines, which we draw in firmly, in limning the disease, are those connected with the external appearance of patients, such as the increase in the size and bulk of the whole body, due, evidently, in part, to changes in the skin, in part to changes in the subcutaneous tissue. Next, the changes in the skin, affecting, more or less, the whole surface, and determining changes in the appendages of the skin; in the hairs, in the glands, and in the organs of touch. In correlation with the changes in the skin, we have to take note also of altered states of mucous membranes, resembling those observed in the skin, and leading again to destruction of appendages, such as the teeth and glandular structures. It is here a point of much importance to remember that the swelling of the skin and mucous membranes is not an ordinary dropsical swelling, does not in any way gravitate from the upper parts of the body to the lower, and does not in any part pit on digital pressure, but is firm and resilient.

"Next comes a group of symptoms indicating in various ways impairment of the functions of the nervous system, such as slowness in muscular movement and tardiness in response to impressions made upon the surface of the body, slowness in thought and action, weakening of memory, disturbance of the balance of muscular actions in the limbs. With these we must associate the quality of the speech and the sound of the voice perfectly typical of the disease, and dependent apparently on the combined effects of the swelling of the lips and fauces, of failure of the movements of the muscles within the swelling, and of default of nervous power in controlling the action of muscles. Further, beyond the above-mentioned signs of dilapidation, we may find various degrees and kinds of mental aberration, and certain mental phenomena, which may be fairly called 'peculiar' up to a certain point.

"The next in the rank of important signs may, I think, fairly be taken to be the lowering of the temperature of the body—rarely, if ever, absent when the disease is fully pronounced. A less common symptom than those already enumerated is the tendency to hæmorrhage following comparatively slight injury, the hæmorrhage being most commonly in the skin or mucous membrane, but sometimes in internal organs.

"Partly with special regard to etiology, we have to consider the question of sex, noting that the affection is very predominantly one of the adult female. In all diagnoses, negatives have to be marshalled among sources of help. We shall find that there is no affection of viscera which can be called characteristic of Myxœdema, although in the course of the disease visceral affections may arise, chiefly from the operation of external and new causes, not wearing, so to speak, the uniform of the higher groups.

"After passing in review the components of the several groups of symptoms and conditions above classified, the relations of the thyroid body assume great importance, seeing that certain changes in that body and its functions are in effect causative of Myxœdema.

"Another set of changes belongs to other diseases, which, in this aspect, have some sort of alliance with it and help us to its explanation.

"We may now amplify the elements of each group of symptoms in succession.

"The often vast and quivering bulk of the body is, I have already said, partly brought about by alteration in the skin, and partly by developments of fat beneath the skin. It is doubtless often due in part to alterations in the muscles and viscera, all partaking of the nature of the change most readily noticeable in the skin. The skin is found to be everywhere dry, and often in many parts is clearly very much thickened in its epithelial layer as well as in the derm. It is exceedingly rough and harsh to the touch, so that, as a patient once remarked, you might almost strike a match upon it—an experiment which, I may say, I have never yet attempted. The varying connections of the skin with the deeper tissues involve considerable variety in the appearance of the swollen parts. For instance, the loss of natural facial expression is at once forced upon one's notice. The skin on the cheeks and forehead is very obviously translucent, dry and firm to the touch, but not nearly so harsh to the rubbing touch as elsewhere. Both upper and lower eyelids are much swollen, and the upper lids droop heavily over the eyeball. They are almost transparent, and look, at first sight, like the eyelids of persons suffering from acute renal disease, but they do not in the least present any pitting on pressure. As a result of the drooping of the upper eyelids, the eyebrows are mostly raised in various degrees, sometimes to a very considerable extent, by the effort to elevate the upper lids above the level of the pupils. The alæ nasi are generally particularly thickened and translucent, giving rise to a broadening of the whole nose. The upper and lower lips alike are so swollen as to destroy the natural expression of the mouth, and to reduce it to little more than a chasm between the inflexible margins. The ears are usually both very much enlarged and thickened. The total effect is that of a mask of sorrowful immobility. There is in this a remarkable resemblance of myxœdematous patients one to the other."

PLATE J.

MYXŒDEMA IN PROGRESSIVE STAGES, AND ASSOCIATED WITH ACROMEGALY.

These three photographs illustrate the condition of the same woman at the several ages of 34, 38, and 57. At the last of these she was, as is shown, the subject of advanced Myxœdema, and exhibited also the physiognomy of Acromegaly. The first portrait represents health. The second shows the earliest stage of the disease, the face being slightly expressionless and sleepy. The progress would seem to have been very slow. We are unfortunately not able to give the details of this interesting case.

As we cannot in connection with these portraits make any statements as to the results of treatment, the case having occurred before Mr. Murray's discovery of the value of thyroid extract, we may venture to supply the omission by another quotation from Dr. Ord's Lecture:—

The Treatment of Myxœdema. By W. W. ORD, M.D., F.R.C.P.

"After Dr. Murray had made his important discovery, Dr. Hector Mackenzie found that the internal administration of the gland or its preparations brought about as marked an improvement and progress to cure as had been effected by the hypodermic injections, and I suppose that the internal administration of the thyroid gland in one way or another is the method of treatment now usually adopted. It appears to me that the administration of the thyroid gland itself, when it can be carefully and regularly maintained, is the most appropriate form of treatment. The gland may be finely minced and administered raw with sugar or salt or may be lightly cooked. The size of the gland, mainly obtained from the sheep, varies a good deal, and such variation is to some extent a justification of the administration of an extract obtained from a number of glands so as to get something like an average. In one case still under my occasional notice, an affectionate husband has been at the trouble to procure regularly thyroid glands from sheep and to prepare them in a raw state for administration to his wife. The original quantity administered was one gland a week, but as the patient has improved the frequency of administration has been diminished, but it still goes on as it has gone on for some years, and at the present moment the lady presents no signs whatever of the disease.

"It is possible to give the thyroid gland too frequently. When the knowledge of its efficacy as administered internally first became known, I gave to a patient, who was so ill as hardly to present any chance of maintaining life, one gland a day for four days in succession. At the end of that time she suffered from violent headache, vomiting and pains in the limbs, with a rise of temperature amounting to 6° Fahrenheit. With such a lesson the gland was administered at longer intervals, namely, of a week to ten days, with ultimately the greatest benefit. But to procure fresh and healthy glands and to prepare them in the proper way involves a great deal of trouble, and its use may be replaced by the administration of Dr. Murray's glycerine extract in doses varying from ten to thirty drops a day, or every second or third day according to the effects produced and to the patient's power of bearing the influence of what we may call now the drug. Still more convenient and not ineffective are the preparations in the form of tabloids now in common use. Some of these contain the dried and crushed gland; others extracts of it, such as the excellent powders devised by Mr. White, the Pharmaceutist of St. Thomas's Hospital. On the whole, I prefer the extracts of the whole gland to any kind of principle derived from it by chemical processes. Perhaps the next best form is the dried and powdered gland of the Pharmacopœia.

"A good deal of extremely interesting work relating to preparation has been done by various observers, and I would draw your attention to 'Observations on the Chemistry and Action of the Thyroid Gland,' by Dr. Hutchison, Demonstrator in Physiology, London Hospital Medical College. According to Dr. Hutchison and others, colloid matter prepared in various ways from thyroid gland is found to contain a definite quantity of iodine, which appears to be present in the form of what has been called 'iodothyrin' (Bergmann)."

MISCELLANEOUS SUBJECTS.

PLATE K.—Albinism in an Indian.

„ L.—Ossifying Cartilaginous Tumours of the Digits.

„ M.—Unilateral Hyperostoses of Skull and Lower Jaw.

„ N.—Rhinophyma.

„ O.—Elephantoid Hypertrophy of Upper Extremity in a Child.

PLATE K.

A HINDOO ALBINO.

Although we have given in a recent Plate a graphic illustration of true Albinism occurring in two Hindoo children, we venture to offer, in association with the portraits of Leucoderma now supplied, another example of that condition. The subject of the photograph was a young Hindoo man, and the woman attending him was his mother. The blinking aspect, caused by exposure to sunlight, is very characteristic, and attention may be asked in contrast with even the most advanced Leucoderma, to the universality and completeness of the bleaching.

PLATE L.

OSSIFYING ENCHONDROMATA OF THE HAND.

This example of the enormous development of cartilaginous tumours is copied from a photograph in the collection of Dr. Sheen, of Cardiff. It was exhibited in the Annual Museum at Swansea in 1903. The patient was a lad named Henry Evans, aged 19. The tumours had been known to be growing since the age of 3. They involved the whole hand, with the exception of the thumb and little finger, and projected both into the palm and upon the dorsum. The radius was curved in its middle with a concavity towards the ulna. It was conjectured that this was possibly due to the weight of the tumour. There was a small hard tumour springing from the anterior surface of the ulna near its middle. Like the radius, the ulna was also curved. There was considerable enlargement of the bones about the elbow-joint, more especially about the humerus, and there was an exostosis at the end of the olecranon. Dr. Sheen amputated the middle of the hand at the wrist-joint, leaving, however, the thumb and the little finger.

The other hand and both feet were free.

The accompanying illustration is taken from a report published by R. Y. Ferguson, M.D., of Pontiac, Mich.:—

"*To the Editor of 'American Medicine'*:—The photograph illustrates an interesting case of multiple chondromas, operated on October 27. The condition is one of comparative rarity, especially in such an exaggerated and neglected form. The history of the case extends over a period of about 35 years, and apparently originated in traumatism. None of the other joints present any abnormal conditions. Three of the fingers were

disarticulated, and together weighed about 24 ounces, the largest one weighing 17½ ounces. The patient also presented a very interesting mitral murmur, disappearing at time of operation to return later. Ether was administered without any unpleasant effect. No tendency toward malignancy was manifest, but destructive cystic changes of the interior of large finger had commenced."—(*From 'American Medicine,' January, 1902.*)

In the Clinical Museum of the Polyclinic there is the cast of a hand showing yet larger tumours than those exhibited in Dr. Sheen's patient.

PLATE M.

UNILATERAL HYPEROSTOSES OF THE SKULL AND LOWER JAW.

This photograph, copied from one in Dr. Sheen's collection, adds another to the list of recorded examples of one-sided hyperostoses of the skull-bones. The patient was a girl named Maria Jones, aged 24. The lumps upon her head had been noticed when she was an infant, and they had been gradually increasing, but had not caused her inconvenience until the last two years. She then suffered from an attack of severe pain in her right ear, and was admitted into the Cardiff Infirmary, when Dr. Sheen removed a piece of dead bone. She recovered, and went back to her place as household servant, but twenty months later was readmitted with a recurrence of ear-ache. It was at this date, August, 1895, that the portrait was taken, and the following is Dr. Sheen's description of her condition.

The patient has a large smooth growth over the centre of the vertex, and another, flatter one, involving the parietal and frontal bones. Another, which projected strongly, formed the frontal region on the left side, and its base was an irregular mass of bone. There was also a growth on the lower jaw near to the left of the symphysis. The face was not symmetrical, the left eye being prominent and at a lower level than the right.

At this date there was recurred inflammation and swelling about the mastoid process near to the scar of the former incision. For this Dr. Sheen performed another operation, gouging the cavity, and dressing it from the bottom.

It transpired that some years previously the patient had been an inmate of one of the London hospitals, where an attempt had been made to remove the growth on the top of her head. It was, however, found to be too hard, and the operation was abandoned.

COMMENTS.

We may, in the above narrative, dismiss the ear symptoms which led to the operations as having had, in all probability, little or no connection with the exostoses. It is with the latter that we are interested. The group to which the case belongs is that in which exostoses and hyperostoses occur in strictly unilateral arrangement on the skull. The writer possesses a skull (which has been repeatedly described) in which such growths are seen on every bone of the face and skull, but with the most definite limitation to the left side. The whole body of the lower jaw is much thickened, and little outgrowths occur upon it close up to the symphysis, but not one beyond it. Another case, almost exactly like Dr. Sheen's, has been recently published by Dr. Mackay, of Devizes, in 'Brain,' with an excellent summary of previously recorded facts.

PLATE N.

RHINOPHYMA.

The photograph which is reproduced in this Plate is copied—as several others in our 'Atlas' have been—from those exhibited at one of the Annual Meetings of the British Medical Association. It was shown by Dr. Arthur Hall, of Sheffield. Dr. Hall informs us that the man declined treatment, and that the history of the case was the usual one. There had been slow increase in growth of the tuberous masses in a man who lived freely. It may be taken as a typical example of the conditions known as Rhinophyma, and formerly as "Cuperose," or Gutta rosea œnopotatorum.

Most of our Atlases contain good representations of this condition, and some of them show much greater hypertrophy than is seen in the present instance. The pathology of the malady is well established. The laws under which hypertrophic processes once set going are apt to assume increase of growth-force in the mere fact of persistence nowhere find better illustration. *Beati possidentes*—fortunate are those who have got possession—is the motto acted upon by the tissues concerned. In many essential features Rhinophyma belongs to the category of Elephantoid hypertrophy. It consists of congestion and overgrowth of the skin and its appendages. No one structure takes precedence of others, for all are concerned. It is neither an angioma, nor an adenoma, nor a fibroma, but the characters of all three are present together. Under the name of Acne tuberosa slight or initiatory forms of Rhinophyma are common enough, and many of them are arrested by treatment. It is only under conditions of persistent neglect and continued subjection to the exciting causes that the state shown in our portrait is ever approached.

The partnership causes and stages of evolution may be stated as follows:—

(1) As a personal peculiarity (of hereditary acquisition, the *damnosa hereditas* of the punster), a thick skin and fleshy nose largely supplied with active sebaceous glands.

(2) A certain degree of feebleness of circulation, permitting easily of capillary or venous congestion.

(3) Frequent exposure to dietetic influences, alcoholic and otherwise, favouring flushing and turgescence of face.

(4) Frequent exposure to external cold, especially whilst under the influence of alcohol.

The above conditions being present, we have first a dusky swelling of the nose-end when exposed to cold, next the formation of comedones on the tip and sides. Following these there appears a persisting hypertrophy and tendency to lobular division, and to implication of the alæ as well as the tip.

The degree and character of the congestion will vary with the degree of vigour of the patient's circulation, and the amount of exposure to the cold air. If the venous element preponderates and there is frequent exposure to cold, the tint will be dusky, and there will be present tufts of venules coming down the sides of the organ; whilst in others, and especially in indoor topers, the colour may be florid (the Bardolph nose).

At all stages comedones, often of large size and with tendency to liquify, are present; and when the disease is advanced, little abscesses or cysts may be developed behind them. The demodex is very frequently present, but it probably takes but little share in aggravating the condition, and none in initiating it. The real causes are those to which reference has been made, and the final result is to be explained by reference to the partially emancipated growth-power of the hypertrophied tissues.

The treatment should of course be in the first place avoidance of the causes, or their reduction to a minimum. Next the clogged sebaceous glands should be carefully and

frequently emptied of their contents, and their open orifices made to imbibe some mercurial ointment or lotion. If the condition is severe, much benefit will result from the use of the needle cautery, pushed deeply into all the gland-ducts. If the stage deserving the name of Rhinophyma has been reached, it will be desirable either to shave off the overgrown parts, or to destroy them very freely with the actual cautery.

Rhinophyma occurs almost exclusively in the male sex, and in obstinate, careless men who, regardless of their appearance, neglect all measures of treatment. Its early stages, however, when inheritance is strong, are now and then seen in women, and in persons much under middle age. It would also not infrequently be an injustice to assume that what are sometimes called "grog-blossoms" necessarily imply intemperance. The power of inherited tendency must always be kept in mind.

An excellent and very detailed account of the pathological anatomy of Rhinophyma, with illustrations from the microscope, may be found in the last volume of the 'Transactions of the American Dermatological Association.

PLATE O.

ELEPHANTOID HYPERTROPHY OF UPPER EXTREMITY IN A CHILD.

We copy this portrait from a photograph supplied by Dr. Sutherland, of the Lahore College. It represents the state of the right upper extremity in a girl aged 5½ years. The notes supplied to us state that the whole of the right upper extremity was involved in lobulated hypertrophy. In some parts it felt hard and fibrous, but in others was soft, as if from simple œdema. The swelling extended to the shoulders, and had even in some degree involved the opposite side. Behind the elbow there was some ulceration. The history given was that the swelling had commenced at the tip of the middle finger when the child was about six months old, and had gradually extended upwards. The increase had been slow at first, but much more rapid during the last six months. The movements at the shoulder and elbow were unrestricted, but the wrist was stiffened by the indurated tissue surrounding it. The movements of the fingers, with the exception of the middle one, were still free.

It will be observed that the photograph shows deep circular indentations at several parts of the limb, the deepest of these being over the wrist. Had these occurred under certain other conditions, they might easily have suggested that some ligature had been intentionally applied; and, if in the present case the history given had been that the condition was present at birth, the influence of amniotic bands might have reasonably been suspected. The history of non-congenital origin of slow and apparently infective spreading, and the fact that the œdematous hypertrophy extended to parts above these constrictions, seems to conclusively negative the latter suggestion. The former is, of course, quite out of the question. The precise pathology of the condition must remain somewhat obscure.

The history points to infective spreading from a peripheral beginning concerning which no explanation is offered. The term elephantiasis lymphangiectica is, perhaps, as applicable as any, but at the same time it does not explain much. In the part of India in which the case occurred elephantiasis in its more ordinary forms is very rare, and in all parts that disease is rarely seen in the upper extremity, and seldom or never in young children. It may possibly have been the case that some slight injury to the middle finger was the cause of the œdema in the first instance, and that the presence of some bacillus allied to that of erysipelas was the cause of its continuance and infective spreading. Had the notes recorded it, it would have been of interest to know whether the recurring febrile paroxysms which are so commonly present in elephantiasis had been observed.

The photograph at first sight might suggest an instance of congenital hypertrophy, since the limb looks as if it were too long, as well as too large. Allowance must be made for focusing and distance in estimating these appearances. The notes entirely negative any suggestion of congenital malformation.

ERUPTIONS CAUSED BY DRUGS.

FIRST GROUP.—ERUPTIONS CAUSED BY IODIDES, BROMIDES, &c.

PLATE CXLIII.—Acute Vesicular Iodide Eruption (in a woman).

„ CXLIV.—Acute Vesicular Iodide Eruption (in a man).

(To be continued in next Fasciculus.)

DRUG ERUPTIONS.

GENERAL REMARKS AND MEMORANDA.

VOLUME 143 of the New Sydenham Society's Library contains an excellent Monograph on Drug Eruptions by Dr. Prince Morrow.* The whole subject is there so fully dealt with that it is not necessary to preface the illustrative Plates which are now offered by any lengthy dissertation. It may be well, however, to briefly recapitulate some of the principal conclusions which have been reached.

The so-called "Drug Eruptions" are almost always due to idiosyncrasy on the part of the patient. Thus they frequently have no relation to the dose or to the long or short employment of the drug. This statement applies especially to all acute eruptions, but finds exceptions, as might be expected, in certain chronic and persisting disturbances of nutrition, such as those which result from long arsenical courses.†

The idiosyncrasy which renders a person liable to an eruption from any special drug can but rarely be referred to any organic disease. In some instances defective elimination by the kidneys, liver, &c., may be concerned, but more commonly it is merely a matter of personal peculiarity, of which no explanation can be given.

There is scarcely a single potent drug in the Pharmacopœia, or the chemists' lists, which may not occasionally show its power by producing a rash on the skin.

Drug Eruptions are usually transitory, often very quickly so. Some of them persist and become aggravated if the drug is continued, but others subside even in spite of such continuance.

They present a very great variety as regards their aspect. Some of the commonest are merely erythematous, a mottled congestion of the surface being their only character. Others present urticarious features, and some, chiefly those from arsenic, are definitely herpetic.

In those which are herpetic a local neuritis must be supposed to be a link in the chain of causation, but in those which are generalized and symmetrical it is not improbable that the poison is conveyed directly to the skin.

Those which are urticarious usually manifest their alliance by intense irritation, but some others are quite devoid of that feature.

The same drug may in different persons produce very different results. Thus the eruptions caused by iodides and allied salts may be erythematous, vesicular, pustular, bullous, or tuberous.

The iodide and bromide eruptions are almost always most severe on the face and extremities, and are often restricted to those parts.

Eruptions due to the terebinthinates (copaiba, &c.) and quinine usually occur most freely on the trunk.

Group I.—ERUPTIONS CAUSED BY IODIDES AND BROMIDES.

Amongst the eruptions which may be produced by the iodides and bromides we have:—

Herpetic.—Usually seen in association with Catarrh.

Vesicular.—Eczema.

Bullous.—Often called Hydroa, and tending towards Pemphigus.

Pustular.—Lichen, Acne, and small furuncles.

* Members of the Society who do not possess our Series will be allowed to obtain this volume separately, at the price of half-a-crown.

† These conditions have been described and illustrated in Fasciculi XVII. and XVIII. of this Atlas.

Ulcerating. — Assuming the features of Rupia.

Tuberous.—"Iodide-Sarcoma."

Hæmorrhagic.—Iodic Purpura.

The Coryza caused by iodides usually disappears in the course of a few days, although the drug may have been continued; but the various forms of eruption usually undergo aggravation until it is disused.

If the iodide be continued, one form of eruption may be merged in another; thus an Acne or Hydroa may ulcerate and become rupial, or may assume the tuberous type.

Iodide eruptions may be fatal either during the acute outbreak, or in consequence of exhaustion from long continuance. In the former it is usually the hæmorrhagic type, and in the latter either the rupial or sarcomatous.

Bromide eruptions may be very severe, but are seldom or never fatal.

When definite Herpes labialis occurs from administration of the iodide, it is usually in conjunction with Catarrh, and may be consequent on a rigor attending the latter, and not directly on the drug itself.

Amongst the coincident phenomena which attend iodide eruptions, we have some which are developed with the first doses, and others which only occur when the drug has been used for some time. Amongst the former the most frequent is Coryza, and with it may occur Pharyngitis, œdema of the larynx, and great depression of strength.

Amongst the symptoms which occur after a continued course, and are associated with furunculoid, rupial or sarcomatous eruptions, we have great depression of spirits, constant chilliness, sensation of pins and needles in the extremities, loss of sexual appetite.

It is a curious and unexpected fact that the long-continued use of the iodide appears to give proclivity to attacks of Erysipelas.

Although it has been suspected that defective elimination of the salt by the kidneys may sometimes be the cause of poisoning, yet it is certain that iodides may be given very freely to patients suffering from contracted kidneys without any special disagreement, and without any form of eruption.

We have perhaps no other drug of which the range of dose is so great as in the case of iodide of potassium. Individual patients appear to differ most remarkably in regard to the ease with which they are influenced by it, and the same patient differs much at different times. Tolerance of the remedy is very quickly produced, and often extends so far as to amount to almost entire insusceptibility of influence unless the dose be increased. It is the very opposite of the cumulative class of remedies, its power being manifested very quickly and being retained, the dose being the same, for but a very short time. One patient may be poisoned by a grain, and another will take two drachms with impunity. It is a remedy which has no fixed dose, and which must be so used in reference to the patient as to produce certain effects regardless of the quantity required for the purpose.

Those who have acquired tolerance of very large doses may afterwards be easily affected by small ones.

In most a small dose to begin with is efficient as a remedy, but some patients experience no relief with anything short of a full one.

Every patient must be studied separately as regards his susceptibility, and the dose arranged accordingly.

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PLATE CXLIII.

BULLOUS ERUPTION (HYDROA) FROM IODIDE OF POTASSIUM.

The subject of this portrait was a married woman, aged 37. She was under the care of the late Dr. Ramskill in the London Hospital, having been admitted May 18, 1869. It is stated that she had heart disease, and she had been treated for this before the eruption appeared on her skin. The eruption was confined to the face and backs of the hands. When this sketch was taken the spots had been out more than a week, and consisted partly of purulent vesicles or small bullæ, partly of "rings the size of sixpences, at the margins of which were vesications of considerable size, while the centres had shrivelled up." The eruption soon afterwards entirely disappeared. The notes state that "Iodide of potassium had been given," but there are no details as to the date when it was begun, or how long it was continued.

It will be seen that this portrait and that of Florence S—— (see Plate CLII.) were taken twenty-five years ago. At that date we were not so familiar with iodide eruptions as now, and hence the imperfection of the notes. They were then diagnosed simply as "Hydroa."

The eruption subsided quickly when the drug was left off, and the patient left the hospital after a few weeks' stay, July 12.

This portrait is a very characteristic one, both as regards the bullæ and the resulting crusts.

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PLATE CXLIV.

ACUTE VESICULAR ERUPTION FROM IODIDE OF POTASSIUM, WITH ŒDEMA OF LARYNX.

The patient whose condition is represented in this Plate was remarkably susceptible to the influence of iodide of potassium. He had had acute symptoms of poisoning from single doses on several previous occasions. He was the subject of chronic rheumatism, for which he frequently sought advice, and by different medical men the iodide had been prescribed for him repeatedly. One or two doses were always sufficient to cause, not only an eruption, but acute conyza and œdema of the mucous membranes. On one occasion he was admitted into the London Hospital suffering from œdematous laryngitis, and with such urgent dyspnœa, that tracheotomy was performed. His attacks of illness lasted only a few days and then passed completely off, the drug of course being suspended. The portrait was taken when the eruption was just beginning to subside. It will be seen that it is of a grouped vesicular character, is bilateral, and is attended by much œdematous swelling of the eyelids. There are vesicles on the prolabium of the upper lip. Excepting this liability, and the proneness to rheumatism, the man was in good health.

It is not without its interest to record that on one occasion the eruption in its early stage was mistaken for Variola, and the patient was placed in an isolation ward. The rapid development of the vesicles, however, led within twenty-four hours to a rectification of the diagnosis. It is to be borne in mind, in reference to most of these portraits, that they portray conditions which were very rapidly changing. If the drug were inadvertently continued, the vesicles would coalesce and form crusts, or large bullæ would appear, with proneness to ulcerate. If, on the other hand, the drug were promptly laid aside, then as rapidly the vesicles would dry up, and the surrounding erythema disappear.

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DRUG ERUPTIONS.

PLATE CXLV.—Face of woman, Iodide Hydroa.

„ CXLVI.—Face of child, Hæmorrhagic Iodide Eruption.

„ CXLVII.—Face of man, Tuberous Iodide Eruption.

„ CXLVIII.—Face and bust of man, Ulcerating Iodide Eruption.

„ CXLIX.—Man's hand, Vesicular Iodide Eruption.

„ CL.—Arm of woman, Iodide Hydroa.

„ CLI.—Face of woman, Fungating Iodide Eruption.

„ CLII.—Arms of a woman, Iodide (?) Hydroa.

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PLATE CXLV.

THE VESICULO-BULLOUS FORM OF THE IODIDE ERUPTION.

The face and neck of a young woman are seen in this portrait to be covered with small bullæ which are arranged symmetrically. The bullæ involve the ear but exempt the tip of the nose. There is one on the lower pro-labium. They are in an early stage (sero-purulent).

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PLATE CXLVI

HÆMORRHAGIC ERUPTION IN CONNECTION WITH A SINGLE DOSE OF IODIDE OF POTASSIUM.

The subject of this case is one of the most extraordinary instances of susceptibility to the iodide of potassium that is on record. The patient, a male infant aged 5 months, died in the London Hospital under the care of Sir Stephen Mackenzie. The infant had been under treatment at its home on account of specific disease and was brought to the hospital in a most critical condition, suffering from dispnœa and with an almost gangrenous vesicular eruption over the whole front of its face. It was stated to have become ill within an hour of having taken the first dose of a mixture which had been prescribed. On inquiry it was ascertained that the mixture contained the iodide of potassium and that the dose which had been administered had been only two grains and a half.

The mother stated that the child began to turn black in the face very soon after taking the dose, and that the lips and eyelids quickly became swollen.

The eruption was vesicular and hæmorrhagic. In addition to the conditions displayed in the face there were numerous hæmorrhagic extravasations over all the extremities.

The child died about 48 hours after admission. The hæmorrhages had taken on a greenish-black colour, and the skin looked as if about to pass into gangrene.

The autopsy confirmed the diagnosis of specific disease.

The case has been published in detail by Sir Stephen Mackenzie.

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PLATE CXLVII.

TUBEROUS ERUPTION FROM THE CONTINUED USE OF THE IODIDE OF POTASSIUM (IODIDE—SARCOMA).

The subject of this case, a middle-aged man, had been taking an advertised remedy containing the iodide of potassium. It was not till after his death that this fact was discovered, when a large number of empty bottles were found in his room. His eruption affected the face chiefly and consisted, as shown in the portrait, of a number of smooth tubers which were more or less grouped, and in some places confluent. Some of them were beginning to ulcerate. The eyelids and the tip of the nose were exempt. How long the drug had been used is not known, but no doubt it had been pushed long after the eruption commenced to appear. This portrait illustrates the condition which has been called "Iodide sarcoma."

Of this form a yet more severe example is given in Archives of Surgery, Plates III. and IV. These tuberous eruptions are seen only in cases in which the drug has been persevered with for a considerable time after the eruption commenced.

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PLATE CXLVIII.

ALMOST FATAL RUPIAL ERUPTION FROM THE IODIDE OF POTASSIUM.

In this instance the iodide had been continued for some weeks in the hope of curing the eruption which it was in reality producing.

The close simulation of Rupia had very excusably led to an erroneous diagnosis and to increased doses of the drug which was producing it. There was comparatively little tendency to fungate, but the sores continued to spread at their edges. The man was reduced to a condition of extreme debility and would probably soon have died if the treatment had not been changed. He began to improve as soon as the iodide was left off, and made a good recovery. The severity with which the disease affects the face is well shown in this portrait as well as in several others. The neck is exempt, and so also are the eyelids. On the trunk it will be seen that there are definite deviations from bilateral symmetry.

It will be seen that everywhere the sores retain a circular or ovoid form. The crusts with which they were usually covered had been carefully removed for the artist's benefit.

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PLATE CXLIX.

VESICULAR ERUPTION BETWEEN THE DIGITS FROM IODIDE OF POTASSIUM.

This portrait exhibits a somewhat unusual condition of the iodide eruption, as it was limited to the clefts between the digits. The patient was a young man in whom, on two or three occasions, the same eruption in the same locations had occurred after the use of the iodide. There was no eruption elsewhere and the two hands were affected alike. It will be seen that the vesications do not pass up the sides of the digits.

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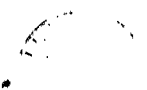

PLATE CL.

HYDROA (VESICULO-BULLOUS) ERUPTION FROM IODIDE OF POTASSIUM.

In this plate we have a good illustration of one of the commonest types of the iodide eruption. The arm is that of a young woman. It is seen to be covered with vesicles, some of them amounting to small bullæ. These occur on the whole of the forearm, hand, and digits. Some are in groups and show tendency to coalesce, whilst others are clearly extending at their borders and show subsidence in the centre and vesication at their margins. The patient had taken iodide of potassium in small doses for several days.

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PLATE CLI.

FUNGATING ERUPTION (PAPILLOMATOUS) FROM THE IODIDE OF POTASSIUM.

The woman from whom this portrait was taken was under the care of the late Mr. James Adams in the London Hospital. She had taken the iodide of potassium for some weeks. There was no generalised eruption, but a few thick vascular tubers had developed. These are seen in very characteristic conditions on the tip of the nose and on the left of the chin.

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PLATE CLII.

BULLOUS ERUPTION WHICH RELAPSED AND WAS PROBABLY CAUSED BY REPEATED PRESCRIPTION OF IODIDES.

This portrait shows the eruption in vesicles almost amounting to small bullæ which tended to coalesce and to produce thick crusts. The eruption was almost confined to the hands and face and was most severe on the latter. It will be observed that the eyelids themselves are exempt, and that the tendency to ulcerate and crust is greatest on the nose and chin. The state of the hands is exactly that to which the term "Hydroa" has often been applied.

The patient was a young married woman (Florence S., aged 20), who was under observation in November, 1868. The evidence as regards her having taken iodides is defective, for no special enquiries were made. She had, however, had some drug prescribed repeatedly, and had repeatedly relapsed, and in the light of what has been subsequently observed as to iodide eruptions there can be little doubt as to the diagnosis. Syphilis had been suspected but was not substantiated. The diagnosis given at the time was "Bazin's Hydroa," but we have since learnt that almost all the eruptions so named are really caused by drugs. In this instance most of the vesicles have either collapsed or broken and have left abruptly-margined excoriations. It may be noted with interest that bilateral symmetry is very accurately observed. There are sores on the ring finger in both hands, whilst the other digits are but little affected. A sore at the base of the index finger on one hand corresponds exactly with one on the other.

The patient was much out of health and had synovial effusion into one knee joint. The notes state that she relapsed repeatedly during the three months that she was under observation, but, as the diagnosis was missed, it is probable that, with suspicion of syphilis on one hand and the known presence of synovitis on the other, iodide of potassium was repeatedly ordered. There were but very few vesications on the face, and none on the abdomen, chest or fronts of arms.

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New Regulations as regards back volumes.

Some resolutions recently adopted by the Council offer important additions to the advantages enjoyed by our members. *In future all members, new as well as old, will, on prepayment of the year's subscription, be entitled to choose one volume from the surplus stock.* This will be without further payment, and will be additional to Fasciculi of the Atlas issued for the year. Part of the Society's library has long been out of print; but there remains on hand a long series of works, many of them of great permanent value, from which selection can be made. Amongst these may be mentioned:—

Laveran's *Paludism and its Organism;*
Pierre Marie's *Diseases of the Spinal Cord;*
Bernutz and Goupil's *Diseases of Women;*
Trousseau's *Clinical Medicine*, vols. iii. and iv.;
Niemeyer's *Lectures on Pulmonary Consumption;*
Charcot's *Lectures*, several vols. on different subjects;
Billroth's *Surgical Pathology*, two vols.;
Guttmann's *Manual of Practical Diagnosis;*
Koch's *Wound Infection;*
Hirsch's *Geographical and Historical Pathology*, three vols.;
Graves's *Clinical Medicine*, two vols.;
Henoch's *Diseases of Children*, two vols.;
Ewald's *Disorders of Digestion*, two vols.;
Pozzi's *Gynæcology*, three vols.;
Helferich's *Fractures and Dislocations;*
Several volumes of selected *Clinical Lectures;*
Spiegelberg's *Midwifery*, two vols.;
Naunyn's *Cholelithiasis;* and many others.

If a subscriber wishes for a work of more than one volume, the payment of one or more subscriptions in advance will enable him to secure all at once, or the additional volumes may be obtained for three shillings each. The Council proposes to keep back a small number of all volumes to meet future needs, and the advantages now offered will of course cease in the case of each work when the minimum is reached. The number at present in hand varies greatly for different works, and as regards some of the most valued it may soon be exhausted. Under another regulation the Council now allows members to select any seven of the Society's volumes for one guinea.

In order to meet the increasing work of the office and to secure greater punctuality in the discharge of its duties, the Council has appointed Dr. Alfred E. Russell, of 9, Wimpole Street, Acting General Secretary, and to him all letters of enquiry should in future be addressed. Mr. Hutchinson will for a time retain the position of Honorary General Secretary. The preparation of the Clinical Atlas remains in the hands of a large representative Committee, and the Society's agency is as heretofore at Messrs. Lewis, 136, Gower Street.

(Correspondence, Addenda, &c., continued overleaf.)

109546

The Annual Museum of British Medical Association.

The Annual Meeting of the British Medical Association is again approaching, and we take this opportunity to remind our subscribers that the temporary Museum which is organised in connection with these meetings affords an excellent occasion for the exhibition of drawings likely to be useful for our Atlas. In past years we have always availed ourselves of these annual collections, and not a few of the illustrations which have been given in our Fasciculi had been in the first instance exhibited in the Annual Museum. Our Atlas may indeed claim to be in some sense an illustrated *memento* of these Museums, and were we more liberally supplied with funds we would gladly do more in this direction. A deputation from the Committee in charge of our Atlas will inspect the drawings, &c., displayed in the Museum at Leicester next month, and we feel sure that those who are zealously engaged in its organisation will not blame us for urging upon our members in their own interest, and in that of Clinical Medicine, that they should exert themselves to make it a success.

Amongst the subjects in illustration of which Fasciculi are in immediate preparation, and concerning which our Committee would like to have further opportunities for selecting drawings, we may name :—

Drug Eruptions (other than iodide or bromide eruptions, of which we have abundance). —We especially desire Copaiba eruption, Quinine rashes, Chloral rashes, and those eruptions due to drugs of recent introduction.

Eruptions due to the Bites of Insects.—Any in which the cause was verified beyond doubt. Mosquitoes, gad-flies, gnats, fleas, bugs, lice, &c., &c.

Variola, Varicella and Vaccinia.—Any portraits, whether photographic or with colour, calculated to assist in diagnosis will be welcome.

Raynaud's Phenomena.—All portraits illustrating symmetrical gangrene of the extremities from whatever cause.

Diseases already illustrated in the Atlas.

The following are some of the subjects which have already been illustrated in the Atlas, but in connection with which further facts will be welcomed :—

The exceptional forms of *Syphilitic Eruption*, more especially the frambœsial type, and those ranked as "malignant syphilis."

The results, immediate and remote, of slow, for the most part Medicinal, Poisoning by Arsenic (Melanoderma, Keratosis of Palms and Soles, Arsenical Cancer, &c.).

Xanthelasma and Xanthoma, especially the so-named diabetic form, if accompanied with good clinical history and record of result.

Photographs, accompanied by radiographs, illustrating Coxa Vara and Sprengel's Shoulder. Photographs, accompanied by radiographs, illustrating the various forms of Colles' Fracture.

We are especially desirous to obtain more illustrations of the disease known as *Hebra's Sarcoma Melanodes*—the "Idiopathic multiple pigmented Sarcoma" of Kaposi. A chief point of interest in this most peculiar malady is the determination as to whether it be not a result of inherited tendency to gout, aggravated, in the case of adults, by personal habits of diet. In all cases the utmost care should be taken to record all facts bearing upon the family history and the patient's antecedents. It is not enough to record simply "no history of gout"; the ascertained facts should be given in detail.

It is to be strongly recommended that all drawings should be accompanied by photographs for the purpose of verification. For many purposes a good photograph is quite as valuable as a coloured sketch.

Colles' Fracture.

In Fasciculus No. XI. (page 125 *et seq.*) we gave some radiograph illustrations of the position of the fragments of the broken bone in cases of Colles' fracture. It is not within the scope of our work to undertake the advocacy of special modes of treatment, but at the same time we earnestly desire to make our Atlas as useful as possible to the practitioner. With that end in view we endeavour to describe clearly the means of diagnosis, and whilst mentioning as much as seems desirable in reference to different means of treatment, to place the reader in a position to judge for himself. In respect to this particular fracture we recorded, without expressing disapproval, that some surgeons of experience believed that in the cases in which the deformity is but slight it is useless to attempt what is called reduction, and that splints are often injurious. Since the appearance of the Fasciculus referred to, a pamphlet has been published by Mr. Andrew Fullarton, of Belfast, in which exception is taken to some of the opinions suggested. It is not, however, accompanied by any radiographic illustrations. We had said that the absence of crepitus, which is so common, was proof that the broken surfaces of bone were locked together and could not by any ordinary manipulation be made to move upon each other. Mr. Fullarton suggests that the absence of crepitus is sometimes due to the fact that the carpal fragment is "high and dry on the dorsal surface of the upper fragment. It would be of much interest if Mr. Fullarton would exhibit his radiographs showing this kind of displacement. It is obvious that such cases would pass right out of the group which the advocates of no interference contemplate. We were careful to define the cases which might be suitably left alone as being those in which the displacement, though characteristic, is not great, and in which no reduction can be proved.

If there is displacement which can be removed by manipulation but which returns when the surgeon's hands cease the extension, a *prima facie* necessity for a splint is established.

If, however, no manipulations are successful in removing the displacement then no splint will effect the readjustment, and all attempts to do it by pressure, pads, &c., are likely to be injurious. If the displacement has been removed by manipulation and there is no tendency to its return, the bones remaining locked together, then there is no object in applying splints.

Three facts ought to be established (preferably by the skiagraph): (1) That there is definite displacement; (2) that it can be removed; (3) that it recurs when the limb is liberated. These points having been established, then certainly a splint is indicated. We demur to Mr. Fullarton's right to give an arbitrary definition of a Colles' fracture and to say that the term is "loosely applied" to all fractures involving the carpal end of the radius. It was precisely the cases with but little displacement which Colles chiefly described and these still constitute a large majority of those now so designated.

Mr. Fullarton will, we hope, exhibit his radiographs in the next Annual Museum. Demonstrations of this kind will be far more effectual than merely verbal controversy. What is asked for is: radiographic demonstration that in cases of slight displacement, without obvious crepitus, the position of the bones can be improved by manipulation, and, secondly, that if so improved there is risk of return if extension be discontinued.

The question at issue is one of great importance in practice, for the suggestion is that when not needful splints are injurious, and that all attempts at rectification by pressure and pads are much worse than useless. The appeal must be not to mere assertion, but to radiograph proof.

Eruptions from Insect-bites.

Those of our readers who have confidence in amicable controversy as a means to the discovery of truth, and who are not averse to being left to judge for themselves of facts, will find interest, not only in the question above referred to, but in that which was opened at page 84, Fasciculus XVIII. It was there suggested that the group of maladies (chiefly those of children) in which recurring pruriginous eruptions occur, and to which dermatologists have given such names as Prurigo urticans, Strophulus pruriginous, Lichen Urticatus and, finally, Urticaria Pigmentosa, are, after all, for the most part not special diseases, and in nowise connected with disturbance of the general health, but simply the results on susceptible skins of the bites of various insects. That at any rate some of them are so was proved by Plate 137, concerning which the facts were unquestionable, but it remains open to doubt whether the suggested generalisation is justified. In our next Fasciculus four plates will be given, the originals of which have been supplied to us by our valued colleague, Dr. Colcott Fox. They will be accompanied by descriptive letterpress from the pen of that distinguished authority, and will have appended to them his designations. Those, however, who believe in the insect-bite hypothesis, will claim that these portraits offer good evidence in support of their creed. It will be for our readers to examine the evidence carefully and judge for themselves. One of the great advantages of pictorial representations is that they afford a substantial basis from which to argue, and give something of precision to debate which might otherwise lose itself in mere words.

Hebra's Sarcoma Melanodes.

We are desirous to add to the list of examples of this malady tabulated at page 9, Fasciculus XXI. One has been published by Dr. Parkes Weber since our last issue. Dr. Weber's patient was as usual a man past middle age. He was a Jew. For the present in reference to gout history the facts are negative, but it is not without interest to note the age and sex are those most liable to gout, and that the race is one very prone to it.

AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY AND PATHOLOGY

CHIEFLY FROM ORIGINAL SOURCES.

FASCICULUS XXIV., OR XVI. OF NEW SERIES.

DRUG ERUPTIONS, &c.

(continued from preceding fasciculus.)

ERUPTIONS FROM BROMIDE OF POTASSIUM.

PLATE CLIII.—Bromide Eruption. Child's face.

" CLIV.—Bromide Eruption. Child's arm and leg.

" CLV.—Bromide Eruption. Girl's face and leg.

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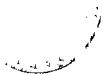

PLATE CLIII.

BROMIDE OF POTASSIUM ERUPTION.

The patient was a child of 4, of fair complexion and delicate skin. Bromide of potassium in four-grain doses three times a day had been administered for a few days, and continued up to date at which the portrait was taken. The heaped-up and discoloured crusts with tendency of the patches to extend by vesication at the borders are well shown. (Portrait by Miss Mabel Green.)

Bale & Danielsson, Ltd., London.

PLATE CLIV.

BROMIDE OF POTASSIUM ERUPTION.

The arm and leg of the same patient whose face is shown on the previous plate.

The tendency of the patches to enlarge by the formation of ring of vesications at their borders is remarkably well shown in the large sores which have formed on the legs.

Hale & Dennistoun, Lith. London.

PLATE CLV.

BROMIDE OF POTASSIUM ERUPTION.

This portrait represents the conditions which were present in a little girl named Hovenden, who came under observation during the summer of 1897. She had taken the bromide of potassium in five-grain doses three times a day for several weeks.

On the face there were numerous small crusted sores without any tendency to fungate, but on one leg one of the sores showed a prominent mass of granulation-tissue, well elevated and circumscribed.

The child was seen again some months later. The mother then stated that the eruption had wholly disappeared in about four weeks after the medicine had been discontinued. A supple scar as large as a shilling remained on the site of the sore on the leg. There were smaller scars on the face also.

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LICHEN URTICATUS.

Dr. Colcott Fox.

PLATE CLVI.—Lichen Urticatus. Common form in early stage.

„ CLVII.—Lichen Urticatus. Varicelliform and persisting.

„ CLVIII.—Lichen Urticatus. Varicelliform.

„ CLVIII *bis*.—Lichen Urticatus with secondary impetigo.

PLATE CLVI.

LICHEN URTICATUS. THE COMMON FORM OF ELEMENTARY LESION.

(Portrait and description supplied by Dr. Colcott Fox.)

Gladys A., aged 2 years, had been reared in the country and fed largely on Swiss milk. The day after coming to live in London, where cow's milk was given, she was attacked by diarrhœa and the eruption evolved. The surface was studded, as depicted in the portrait, with red congestive macules, the size of the little finger nail, centred by an obvious darker red papule. The child was only seen once more a week later, when the eruption was much less marked.

The portrait illustrates the most common form of elementary lesion characterising this eruption, but it is unusual to observe them in such profusion in the daytime. Some, however, will be found mixed with the more persistent papules in almost every case if a careful search is made.

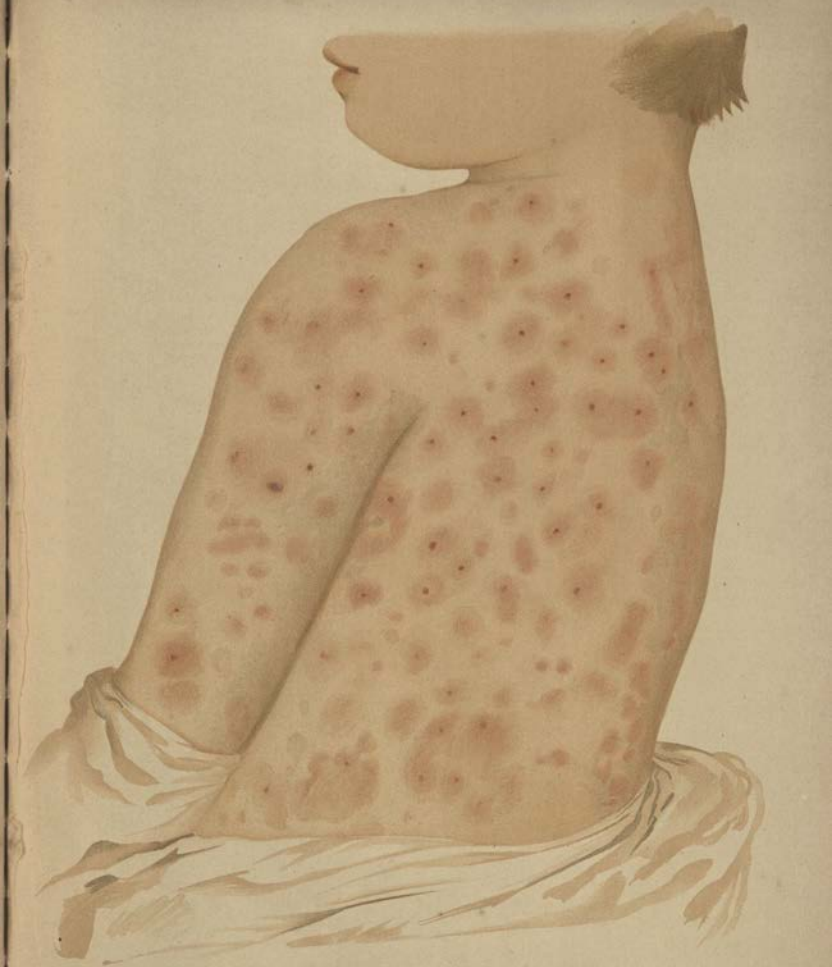

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PLATE CLVII.

LICHEN URTICATUS WITH PERSISTING PAPULES AND VARICELLIFORM LESIONS.

(Portrait and description supplied by Dr. Colcott Fox.)

Sydney R., aged 3 years, had been attending the out-patient physician for twelve months for general ill-health, and the eruption had existed on and off for about thirteen months. At the time the drawing was executed there were a few lesions on the scalp and face; others more numerously scattered over the trunk and limbs, excepting the large flexures. The soles of the feet were involved, but the palms not so. The lesions were most numerous on the forearms. The portrait illustrates the prurigo-like papules left by the elementary lesions, and also the rarer varicelliform type of elementary lesion in which the ephemeral congestive macule is centred by a vesicle. At a subsequent visit I noted congestive macules with an urticated central papule, and another time lesions completely urticated and white.

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PLATE CLVIII.

LICHEN URTICATUS.. THE VARICELLIFORM PHASE.

(Portrait and description supplied by Dr. Colcott Fox.)

Leonard A., aged 13 months, was brought to me on February 25th, 1899, and the eruption had appeared suddenly twelve days previously after the child had eaten fish the afternoon before. At first there were only a few spots, and others followed chiefly at night. When seen by me the eruption was very copious, occupying the scalp, face, body and limbs, including the palms and soles, but the great flexures least. There was clustering in places. The lesions were nearly all vesicular, and extraordinarily like varicella. Some were almost pemphigoid. Some displayed a congestive halo around the central vesicle, and the mother said that was how they all evolved. The medical man called in at first made the diagnosis Varicella, but later pronounced it Urticaria. The other children of the family were not affected. The mouth was free. I could not excite factitious urticaria. On March 4th the mother reported that on the preceding night there had been a copious outburst of red blotches, and I found the eruption much thicker, but *no longer vesicular*. The eruption was papular, and involuting to form flat-topped, smooth lesions with a central depression, extraordinarily like lichen planus. The back was covered. I noted that it was surprising to observe such a complete change in the picture. The child had been sleepless and crying all the week. On March 18th I observed two large pemphigoid bullæ on the hand. On April 8th the child was losing flesh, and the groin glands were enlarged. The eruption was again vesicular, and many lesions were scratched and impetiginous. I watched the various phases of this eruption for some weeks, but although the child improved in health and the eruption mitigated it was not cured.

Hale & Iremonger, Lith., London.

PLATE CLVIII *bis*.

LICHEN URTICATUS.

(Portrait, description, and general remarks supplied by Dr. Colcott Fox.)

This portrait was made to illustrate the altered features when the lesions are complicated by secondary pyogenic organisms. The eruption now has the aspect of a small-patterned ecthyma. I have mislaid the notes of this case.

General Remarks on Lichen Urticatus by T. Colcott Fox, M.B.(Lond.), F.R.C.P.

Physician for Diseases of the Skin to the Westminster Hospital, and Visiting Dermatologist to the Ringworm Schools of the Metropolitan Asylums Board.

Lichen Urticatus (Bateman), or *Strophulus*, as I prefer to call it, is one of the most frequent eruptions met with in young children in London hospital practice. The eruption is almost always bilateral, but may be limited or generalised, the lesions scanty or copious, usually disseminated without order or sometimes casually crowded into a group (*confertus*), but not confluing into patches. It may commence at any time in the earlier years of life from birth onwards, and appears to be a frequent sequence to vaccination and the acute specific fevers. It may be a passing affair, but is usually characterised by successive outbursts at more or less interval, or by a steady evolution of fresh lesions. It may last, in rare cases, to adolescence, but though described in the adult I have never identified it. For the most part it ceases after the earlier years. The accompanying irritation is great, and the baby frequently disturbs the whole family night after night by its restlessness and crying. The eruption chiefly evolves at bedtime, and it is notably worse in the warm months.

When a child is brought for relief in the daytime the picture most commonly presented is that of a number of prurigo-like papules from a hemp seed in size downwards disseminated without order, and hence the affection has been called *Infantile Prurigo*. But if a complete search be carried out it is rare not to find one or more examples of the complete elementary lesions. This consists in a lively red, rounded, congested macule, the size of the little finger nail, centred by a darker red papular projection. This congestive macule is ephemeral, leaving the papule to a somewhat longer life. The mother will often state that at night the child is "smothered in blisters," *i.e.*, presents a copious eruption of blotches. That this eruption is closely allied to common urticaria is shown by the fact that the whole elementary lesion is frequently urticate and porcellaneous in aspect, and sometimes the central papule alone (see Plate in Tilbury Fox's Atlas).

But there are other phases of this multiform eruption. The centre of the elementary lesion may be vesicular and then chicken-pox lesions are closely simulated. I have never seen them on the mucous membranes. I believe this phase to be the *Varicella-Prurigo* of Mr. Hutchinson (see plate Sydenham Society's Atlas). It is only a step further for the contents of the vesicles to become pruriform, and then I have seen the eruption mistaken for variola. On the hands and feet the whole elementary lesion may be blistered to form a pemphigoid bulla. Lastly, as it is an intensely itching eruption, the lesions may be excoriated by scratching, and the primary eruption masked by infection by pyogenic organisms (impetigo and ecthyma).

In a paper (*British Journal of Dermatology*, 1890) I have pointed out the alternations of these various phases in the course of chronic cases.

PLATE CLVIII *bis.* *(Continued.)*

The *etiology* is probably complex. The natural instability of the cutaneous vaso-motor system in early childhood may be further weakened by various debilitating and disturbing influences such as hereditary syphilis, athrepsia, rickets, vaccination, the acute specific fevers, and so on. Then various other influences come into play, such as gastro-intestinal disorders set up perhaps by ill-feeding, irritating clothing, &c. Mr. Hutchinson attaches far greater importance to the influence of insect bites than I do. In the first place cases are met with in private practice in which causation by insect bites is out of the question. Then, as a rule, mothers will not entertain the idea of such causation. Lastly, there is a marked absence of traumatism of the skin such as we see in the typical flea "bite."

The *Diagnosis* rarely presents any difficulty to the experienced observer. The careless frequently confound this eruption with scabies. Occasionally certain temporary phases are puzzling, and I have already referred to simulation of lichen planus, varicella, and variola. Whether the prurigo of Hebra is only an exceptional inveterate phase of lichen urticatus would require too much space to discuss here. I believe they are distinct diseases.

Treatment might easily be expanded into a long chapter. The gist of the matter is that careful inquiry should be directed into the history of the case, the feeding, the clothing and hygienic conditions, and constitutional state, of the child, and the treatment framed in accordance with the conclusions arrived at. There is no specific remedy. The local palliatives useful are those adopted for common urticaria. Pus formation demands antiseptic cleansing by baths or otherwise, and the application of a healing salve. Where a child lies in distress all night a sleeping draught is desirable.

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PEMPHIGUS VEGETANS.

GENERAL SYNOPSIS OF THE PEMPHIGUS GROUP.

PLATE CLIX.—Pemphigus Vegetans in a man.

PLATE CLIX.

PEMPHIGUS VEGETANS.

The patient whose condition is displayed in this plate afforded a typical illustration of Pemphigus Vegetans. He was a robust man, a German by birth, and by race a Jew. He had never suffered from syphilis, and no special cause could be assigned for his illness. His earliest symptom had been, as in not a few other cases, a troublesome, sore mouth. He thought that the corners of his mouth were the parts first affected, but he subsequently was liable to have "blisters" form on the lips and inside the cheeks. For these various measures of treatment were employed, and amongst others he was salivated under a mistaken diagnosis of syphilis. A year or two later he began to chafe and excoriate in his groins, and after another year bullæ began to form on his skin. Thus far he had resided in South Africa, but he now returned to Europe, and was a year under the care of Prof. Köbner, in Berlin, by whom his case was published. His groins, where vegetations had formed, were scraped, and he ultimately returned to South Africa, practically well, but still liable to recurring sores in the mouth. After two years of comparative immunity a severe relapse occurred. His skin now became covered with bullæ, and vegetations grew in his axillæ and groins. He was finally brought to England in a most pitiable condition, blistered and excoriated from head to foot. The portrait was taken after some weeks' treatment by opium and arsenic, and when the number of bullæ had been much reduced. These drugs showed very definite power in restraining the eruption, but did not cure, and after about eight months of suffering he was relieved by death. The following schedule displays the course of the disease in a clear form :—

SCHEDULE OF CASE.

Year.	Age.	
1885	26	First began to be liable to sores at corners of mouth and inside cheeks.
1886	27	In strong health, but liable to recurring sores in mouth.
1887	28	Still liable to sore mouth, and beginning to suffer from irritation between thighs and scrotum.
1888	29	Visited Berlin from Kimberley on account of his mouth, and was cured for a time under arsenic.
1889	30	In Kimberley, and again suffering from his mouth and groins. He was now very stout.
1890	31	Returned to Berlin still suffering from his mouth and groins; "Pemphigus Vegetans" diagnosed. Arsenic again given.
1891	32	Under Prof. Köbner's treatment in Berlin, and was again cured and remained quite well for several months.
1892	33	Well with exception of liability to blisters in the mouth.
1893	34	In good health, but still liable to relapses of stomatitis.
1894	35	A severe relapse of Pemphigus in January. Came to England covered with bullæ and vegetations in August.
1895	36	Died in April exhausted by continued inflammation of the skin.

He had retained to the last a good appetite and digestion, but he was emaciated to skin and bone, and his skin adhered to his bones like that of a mummy. Most of his joints were contracted and stiff.

As regards the effects of arsenic there could be no doubt that at all stages it had manifested very definite power in restraining the formation of bullæ, and in the earlier years it had effected a temporary cure on several occasions. To its use he probably owed his life in 1890, when the

conditions were very threatening. During the last stages there were symptoms of chronic arsenical poisoning, but the patient could never be persuaded to leave it off.

It is to be noted that in this instance the "vegetans" tendency preceded the development of bullæ. At the time of the patient's coming under treatment in Berlin in 1887 there were no bullæ, and the soreness in his groins were attributed by the patient to chafing, as he was very stout. When again in Berlin in 1890 and 1891 he still had no bullæ or very few, but his groins were occupied by large patches which looked like condylomata. These were scraped and cauterised repeatedly. Prof. Köbner always asserted that the disease was not syphilitic, but others, whom he consulted in South Africa, said that it was so, and used iodides and mercury freely, with, not improbably, some amount of ill influence upon the subsequent course of the disease. The case may be found recorded in more full detail in *Archives of Surgery*, Vol. viii., page 129.

It may be stated that for some months before death all tendency to the production of papillary out-growths had ceased. Even at the time that the portrait was taken the vegetations were withering, and the plate does not represent them in full luxuriance. They were evidently in some instances located by the moisture of the part, and they occurred almost exclusively in the armpits and groins. In some instances they were, however, produced on the skin of the abdomen, and there was a definite tendency for them to grow at the angles of the mouth.

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PEMPHIGUS VEGETANS

WITH GENERAL REMARKS ON THE PEMPHIGUS GROUP OF MALADIES.

ALTHOUGH the designation "Pemphigus" may be suitably claimed as applicable to most forms of dermatitis which are characterised by the formation of bullæ, it should be refused to all which are of local origin. A constitutional cause is to be presupposed in all cases, and in all the eruption should be bilateral and more or less general.

It is to be understood that bullæ are not necessarily present in later stages of the disease and that the dermatitis which produces them may cause also papillary over-growth (vegetans) or dry epidermic exfoliation (foliaceus). It may be conveniently assumed that the influence which determines the formation of bullæ is an inherent peculiarity of the skin which permits the free effusion of fluid between the rete and the epidermis and in which the latter is easily detached (epidermatolysis). Thus, in a person having this condition of comparatively loose epidermis any congestion of the rete may result in the formation of bullæ without reference to its special cause. It may be added that arsenic appears to have the power of diminishing this tendency to fluid effusion, and thus, although it may not remove the congestive dermatitis it much restricts the formation of bullæ.

The bullous dermatitis to which the term pemphigus is applicable is always in itself productive of much febrile irritation and rapidly causes serious exhaustion. All forms of pemphigus are prone to recur. No definite tendency to spontaneous disappearance is observed in any form of pemphigus, and unless successfully treated by drugs they usually go on from bad to worse.

We may conveniently recognise the following type-forms of pemphigus, arranged in relation to cause. We exclude all in which the cause is local only.

SYPHILITIC PEMPHIGUS.

Of this we have two forms, one in connection with acquired disease and the other with inherited taint. In the former, the dermatitis which occurs in the secondary stage of syphilis results in the production of bullæ, the eruption in all respects resembling the well-known pemphigus diutinus. It is an extremely rare eruption. Two well-characterised examples are recorded in *Archives of Surgery*, one of them with a coloured illustration. In both constitutional disturbance threatening death occurred, and in both the use of arsenic was required to control the eruption, as it was not amenable to mercury.

When pemphigus occurs in inherited syphilis it usually affects the hands and feet only and is observed within a week or two of birth. It is supposed to be almost invariably fatal, by the occurrence of convulsions and in a very short time. It is rare, and well observed cases are *desiderata* in our literature.

DRUG PEMPHIGUS.

In some cases the iodides and bromides may cause bullous eruptions. The bullæ are usually small and the enclosing layer of epidermis thin and delicate. The face and hands are almost invariably affected, but not to the exclusion of other parts. It was probably to these cases chiefly that the term "Hydroa" was formerly applied by Bazin and others. The eruption

usually subsides quickly when the drug is left off. (See portraits in the present and preceding fasciculi.)

Pemphigus Diutinus.

This name is applicable to most of the cases described and figured under the name of "pemphigus." The eruption is symmetrical and universal, the bullæ are often large, and in the early stages they stand on skin which is not involved in congestion. It may occur at any age, and it is hardly ever possible to assign any cause for the first outbreak. Its subjects are often children. It may be a very acute disease and bring about death in a few months or even weeks. The mucous membranes are often affected, and a sore mouth sometimes precedes by a considerable period the eruption on the skin. The degree of exhaustion is usually in ratio with the extent and severity of the dermatitis. Arsenic often appears to possess specific efficacy, and entirely removes the eruption and restores the patient to health, but there is always risk of recurrences. In cases in which arsenic does not cure it usually restrains the tendency to the formation of bullæ, and more or less changes the type of dermatitis. The facts as regards age, influence of season, tendency to recur, effect of pregnancy and lactation, and the efficacy of arsenic, are very similar to those which are observed in the instance of common psoriasis.

Acute Pemphigus.

The term diutinus implies, of course, more or less prolonged duration. It may be that the adjective is sometimes earned by the partial success of drug treatment. It is certain that there are cases which commence much in the same manner as those which become chronic, but which run a rapid and very acute course. It is doubtful whether any or all of these should be sharply differentiated from the diutinus form, or whether they are not simply very severe examples of it. In these the mouth is usually severely affected from the first; arsenic fails to control the malady, and death occurs within a few months, or even weeks, of the onset. It has been suspected that in some of these cases contagion from animals, sheep, &c., has occurred, but nothing in this direction has been conclusively established.

Pemphigus Herpetiformis.

This name is applicable to certain cases in which the bullæ or vesications are arranged in a somewhat paniculate manner like those of herpes zoster. The resemblance is, however, never very close, and the eruption is always general and symmetrical. There is no tendency to spontaneous recovery, and in most features the cases conform to what has been said above as to pemphigus diutinus. There is the same tendency to recur, and not infrequently the same amenability to treatment by arsenic. It is the disease to which Dr. Duhring has given the name "Dermatitis herpetiformis," but it is obviously a modification of pemphigus and has no very near alliance with herpetic maladies.

Pemphigus Gestationis.

In the cases which have received this name there is a liability to recurrence of eruption during either pregnancy or lactation, sometimes the one and sometimes the other. The patients are, however, seldom absolutely free from it at other times, and not unfrequently recurrences take place independently of those physiological conditions. It is well known that psoriasis frequently recurs or undergoes aggravation or disappears under the same associations, and there is perhaps but little reason for detaching these cases from pemphigus diutinus. (See portrait in former fascic.)

Pemphigus Foliaceus.

This name is given to certain very rare but well-characterised cases in which a diffuse and generalised exfoliative dermatitis has followed a bullous one. The bullous stage has usually been of but short duration and it is never repeated. The exfoliative one is not amenable to arsenic and the cases are practically incurable. They are not, however, attended by the rapidly increasing debility which characterises pemphigus, and the patient may live for years.

The eruption which has been described under the name of *Cheiro-pompholyx* and which some have claimed as a dyshidrosis is probably more nearly allied to erythema multiforme than to pemphigus. It is attended by large bullæ on the hands and vesicular eruption between the toes, but it is of short duration and disappears completely and spontaneously.

Pemphigus Vegetans.

Lastly, we have a form of pemphigus disease in which, on certain parts of the body, there is a tendency to papillary outgrowth. On the trunk and on the greater part of the limbs, bullæ of the characteristic character are formed, but in the armpits and the clefts or the groins large areas are involved in condyloma-like vegetations. These are also seen at the corners of the mouth. The occurrence of these vegetations is not usually observed in the early stages, and when it manifests itself it usually denotes that the case will prove fatal.

The case illustrated in Plate CLIX., to which the above remarks are introductory, affords an excellent example of this malady. As such it was carefully studied and reported on, first in Berlin (by Prof. Koebner) and subsequently in London. The only unusual feature which it presents, is that the tendency to "vegetations" was displayed early and before any bullæ had appeared on the skin.

SUMMARY.

It will be evident on a little consideration that the forms of generalised bullous dermatitis above enumerated, although differing in detail, exhibit affinities in many directions. To this statement the cases due to congenital syphilis constitute possibly the only exception, and they ought, perhaps, to be excluded from the family group. In them there is no trunk eruption, and no suggestion has been made that arsenic is beneficial. In those due to acquired syphilis we have not only a general eruption, but there is the same rapid failure of health and threatening of a fatal event which we witness in common pemphigus, and the specific remedy for the latter is requisite to save the patient. We are obliged, therefore, to suspect that some underlying sameness of constitutional predisposition gives peculiarity to this syphilitic manifestation. The rapidly fatal cases of acute pemphigus may be plausibly held to be only examples of exceptionally severe onset of the more ordinary form.

We may then say that all the members of the pemphigus family have the following points in common :—

(1) The onset may be sudden and severe, and usually occurs to persons apparently in good health.

(2) In some cases the skin eruption may have been for a long time preceded by recurring attacks of sore mouth.

(3) The bullous eruption is always followed by marked failure of health, and if not cured by drugs a fatal result will follow ; for long pemphigus was regarded as a mortal disease, and it might be so still were it not for the influence of arsenic and other drugs.

(4) Arsenic in almost all forms manifests specific power ; not in all cases curative, but in almost all restraining.

(5) In all cases which have been cured (usually by arsenic) there is risk of relapse.

(6) In the female sex, the influence of pregnancy and lactation are often evident in causing tendency to relapse.

(7) When the eruption is cured by arsenic, the restoration of health is usually complete.

(8) In the cases in which the eruption is brought out by iodides or bromides, we have to suppose constitutional predisposition, and it is well established that arsenic is preventive.

CORRESPONDENCE, ADDENDA, &c.

The present Tasciculus contains the four plates illustrating Lichen Urticatus to which we adverted in our last issue. As was then explained, there is difference of opinion as to the cause of the eruptions which receive this name, and which are so admirably illustrated in these plates. Dr. Colcott Fox has, in the letterpress appended to the plates, explained his reasons for regarding the eruption as due to disturbance of the general health, and as requiring for treatment the prescription of alteratives and antacids. He has also stated his objections to the creed which attributes these eruptions to the pricks of insects. In order that the two schools of opinion may be fairly represented we append the following statement, which has been drawn up for us by a member of the committee in charge of the Atlas, and a disciple of the Flea-bite school. He writes :—

"I incline to regard Dr. Fox's portraits as representing the results of insect-bites (fleas or bugs), for the following reasons :—

"In Plate 156 the faintly margined erythema, which most of the patches show, is exactly like that which often, indeed usually, results from flea-bites, whilst many of them show the central puncture quite distinctly.

"In Plate 157 the spots are in very various degrees of development, and those which are recent show small bullæ on an erythematous base exactly like those shown in plate 137 in which the cause was known to be flea-bites. The grouping of the spots, whether old or recent, is also that of bites, being quite irregular, and running more or less in lines ('constellation pattern'). The resemblance of this plate to plate 137 in all its features is very close.

"In Plate 158, as in the preceding one, the spots are of very different ages, some being mere stains, whilst others are acutely congested pustules or vesicles. They are also arranged in lines and constellations. Especially is it to be noted that the recent spots are in groups, as if the same insect had pricked at several closely adjacent places. They do not occur in circles or ovals, nor are they in leashes like those of herpes. Their location is quite irregular and capricious.

"In Plate 158 *bis*, the eruption appears to have been vesicular and to have been scratched; many of the spots are crusted, and show superficial ulceration. The grouping of the spots is again as in the two preceding, linear or irregular. There are in association with recent vesications many old stains, proving that the conditions seen had been produced by successive crops.

"In all four cases the subject is a child of apparently a fair complexion and delicate skin, just such as would be likely to be attractive to fleas and to resent their attacks.

"In case, Plate 156, it is especially recorded that the child had been reared in the country, and that the eruption was evolved *the day after coming to London*. The eruption is expressly described as consisting of 'red congestive macules the size of the little finger nail, centred by an obvious darker red papule.'

"In the subject of Plate 158 the eruption had, in the first instance, appeared suddenly, and had then consisted of only a few spots. It had been sustained and augmented by other outbreaks, which had *occurred chiefly at night*. They displayed as their first stage a 'congestive halo around a central vesicle.' During one particular night there had been 'a copious outburst of red blotches.'

"Thus, then, I claim that in these important plates not only the non-symmetrical and constellation-like arrangement, but the history of nocturnal accessions, and in one of a sudden attack on coming to London, favour the belief that the conditions shown were really caused by insect-attacks. The statement as to ill-health in two of the patients does not in the least militate against this view. Flea-bite eruptions, when severe, very seriously interfere with the child's health. As has been observed (see page 84, *et seq.*), they sometimes cause fever to the extent of temperature 103°. By disturbing the child's rest, they may cause loss of strength and flesh. Respecting the subject of Plate 158, Dr. Fox records 'the child had been sleepless and crying all the week,' and in case, Plate 157, the eruption had been present on and off for thirteen months, and its subject had been out of health for twelve.

"The fact that some characteristic eruptions of this type occur in the children of well-to-do and cleanly families, is not evidence of the slightest value against flea-bite origin, for I have repeatedly seen them under such circumstances when the cause was well known and freely acknowledged. There is, however, the difference between the cases seen amongst the poor and those amongst the rich, that the latter very rarely become chronic. Conditions such as those shown in Plate 156 may not infrequently be seen and with like history, but not such as those in Plates 157 and 158 *bis*. Amongst the well-to-do the cause of the attack is usually promptly removed, and although repeated attacks may occur, the disease rarely or never becomes chronic. This fact suggests that there is one simple measure which may constitute at once a test of diagnosis and a means of treatment: let the child be removed from its home and placed in a clean hospital bed. This measure was adopted in a case of urticaria pigmentosa under the care of Dr. Radcliffe Crocker, who wished to study the primary lesions. It happened, however, that whilst the child was in a bed in University College Hospital no primary lesions ever showed themselves."—J. H.

AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY AND PATHOLOGY

CHIEFLY FROM ORIGINAL SOURCES.

FASCICULUS XXIV. bis, OR XVII. OF NEW SERIES.

RADIOGRAPHS OF FRACTURES AND DISLOCATIONS.

(Chiefly Upper Extremity.)

PLATE A.—Injuries of lower Epiphysis of Humerus (3 figures).
„ B.—Detachment of lower Epiphysis of Humerus.
„ C.—Detachment of lower Epiphysis of Humerus (back view).
„ D.—Fracture of Humerus near the elbow.
„ E.—Union of Fracture of humerus in bad position.
„ F.—Transverse Fracture of Humerus.
„ G.—Fracture of both bones of Forearm.
„ H.—Fracture of both bones of Forearm.
„ I.—Multiple Fracture of both bones of Forearm.
„ J.—Congenital absence of lower part of Ulna.
„ K.—Partial Dislocation of Foot, with Fracture.

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THE NEW SYDENHAM SOCIETY.

PLATE A.

INJURIES TO THE ELBOW IN YOUNG PERSONS.

Fig. 1.—From a photograph, showing displacement backwards of the forearm after detachment of the lower epiphysis of the humerus. The lower end of the shaft projects strongly forwards under the soft parts. The case was treated on the rectangular back splint with good results.

Fig. 2.—Skiagraph of a case of backward displacement of the lower epiphysis of the humerus, showing the usual deformity, taken from a boy of five, eight days after the accident. (*See text below.*)

Fig. 3.—From the same case as the preceding figure. By full flexion of the elbow the epiphysis has been brought into almost perfect position. This position was kept up for three weeks, and an excellent result obtained.

The lower end of the humerus is not complete in its ossification until the eighteenth year, and during the preceding period its condition is undergoing progressive changes. The formation of bone in the epiphysis is accomplished from four different centres, which eventually become merged. In the third year after birth bone is formed in the capitellum. In the fifth, a nucleus appears in the internal condylar eminence, whilst in the trochlea it is not till the eleventh or twelfth, and in the external condylar eminence not till the fourteenth. Thus viewing the bars of cartilage which intervene between the ossifying portions as the "weak parts," and as these most likely to give way under violence, it is obvious that the conditions vary much at different ages. Up to nearly the age of four any breakage will involve only parts which are wholly cartilaginous and which are not likely to give way in any predetermined direction, and in which no crepitus could be produced. At the same time it may be understood that whatever of crushing or displacement may be caused at this age will probably be well repaired by the re-moulding of the part in subsequent years. Some imperfection of growth is the only ill consequence likely to result. At later periods, and up to the age of sixteen, the epiphysis may be detached almost as a whole, the line of separation passing transversely from condyle to condyle. In such cases the displacement is usually of the forearm and elbow backwards, the denuded end of the humeral shaft projecting strongly under the brachialis anticus. The appearances produced in this form of injury are well shown in the appended woodcut (from a photograph taken in a recent case). The treatment of such cases is by a hollow rectangular back splint and a short one in front of upper arm, great care being taken to effect complete reduction. It must be remembered, however, that in many cases the line of detachment is not cleanly transverse. A vertical bar of cartilage separates the two main ossifying centres up to a certain age, and still later the two condyles remain detached, and may be torn off either separately or with the rest of the epiphysis. Thus these injuries may be, and in practice frequently are, variously complicated. No two cases are exactly alike. Nor, indeed, does the radiograph always help the diagnosis much, and in many cases it may be quite impossible, even by the aid of radiography, to determine the precise nes of fracture. Nor, fortunately, is this necessary for treatment. The surgeon must determine that there is no lateral displacement, and then be content to put up the limb with the elbow well flexed.

The paramount importance of avoiding anything approaching to the straight position in the treatment of these accidents cannot be exaggerated. They are cases which may easily lead to great loss of professional credit, as well as serious detriment to the patient. In most cases a right-angled back splint may give good results, but if there be any difficulty in securing good positions, one of more acute flexion should be tried. The latter is strongly recommended by the English Editor of Helferich's work, from whom we quote the following and borrow the accompanying illustrations:—"One important fact has lately become clear owing to the use of radiography. The mass of bone which is felt just above the bend of the elbow in so many cases of separated lower epiphysis and the like at the end of treatment which is put down to excessive callus, and which so much limits the movements of the elbow, is not really callus at all, but the end of the shaft which was originally displaced and never reduced.

"The accompanying figures illustrate this well. The first shows the side view of a separated epiphysis in a boy aged five, taken eight days after the accident. The injury had been carefully treated from the first on a splint, and the displacement was supposed to have been corrected. The skiagraph shows that the diaphysis still projected strongly, and that the projection would form a permanent obstacle to full flexion. . . . . The next figure shows the result of as full flexion of the elbow joint as the swelling would allow. It will be seen that the epiphysis has glided into almost perfect position, and there was no difficulty in keeping it there."

FIG. 1.

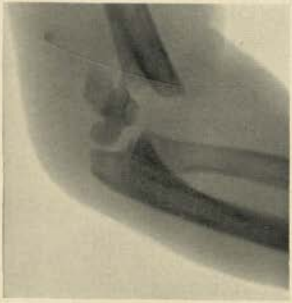

FIG. 2.

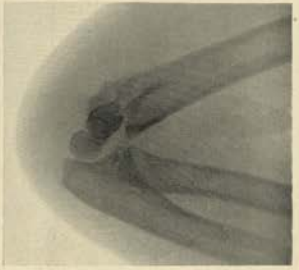

FIG. 3.

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PLATES B. AND C.

DISLOCATION WITH COMPLICATED FRACTURE OF LOWER EPIPHYSIS OF HUMERUS.

The radiograph, which is reproduced in this and the following plate, was taken a month after the injury. It was at this date that the patient came for the first time under Mr. Jones' observation. The patient was a girl of 8, who had sustained a severe fall upon her elbow. The case had been treated almost in a straight position, and the elbow had become almost fixed. Flexion and extension were much limited, and so also were pronation and supination.

The radiographs show displacement of the radius and ulna backwards, with fracture of the lower epiphysis of humerus into several fragments. Owing to the large amount of unossified cartilage still present, the outlines of the fragments are but very indistinctly seen. The prints may be taken as illustrating not only how much but how little radiographic reproductions can assist in diagnosis. It is not at all easy by contrasting the two prints or carefully examining either one to determine the exact conditions. Diagnosis by careful and skilled fingers would probably be a more trustworthy guide to treatment than these radiographs.

The case well shows the ill results of treatment in other than the flexed position.

From the Jones-Morgan Collection.

Bale and Danielsson, Ltd., London.

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PLATE D.

UNITED FRACTURE OF LOWEST PART OF HUMERUS.

The patient in this instance was a lady, aged 70. The humerus had been broken a little above the condyles. Repair had been secured in excellent position. The forearm, with the condyles, is displaced a little backwards. The almost entire absence of evidence of ensheathing callus would suggest that no great displacement (with tearing up of periosteum) had occurred in the first instance.

From the Jones-Morgan Collection.

Dale and Danielsson, Ltd., London.

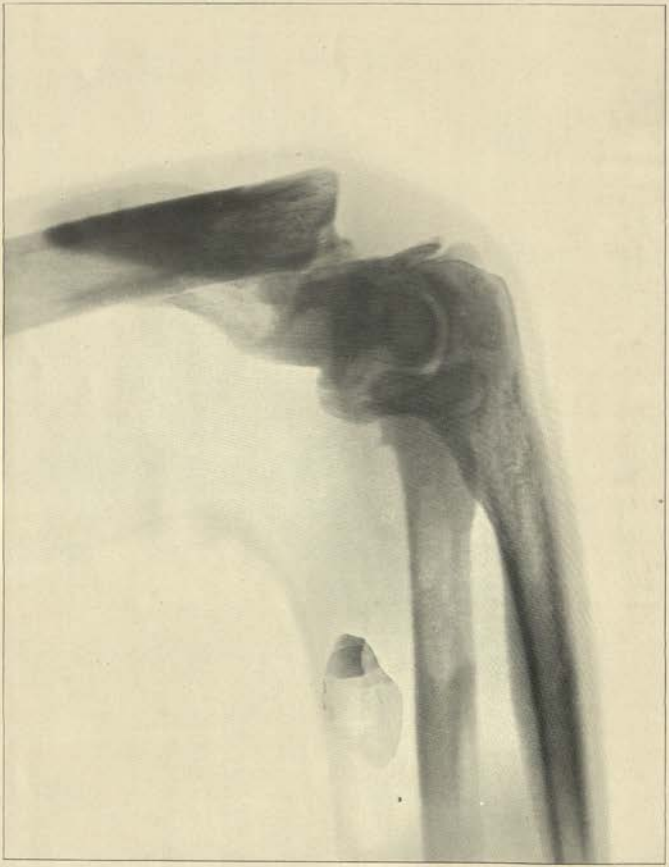
PLATE E.

UNION IN BAD POSITION OF FRACTURE IN LOWER PART OF HUMERUS.

The fracture in this case is at a not unusual position, about two inches above the elbow, but the displacement of the lower or elbow fragment forwards is probably much less usual than the reverse. It is obvious that in the first instance no satisfactory reduction had been effected, union had been allowed to take place with great displacement, the front aspect of the upper fragment still resting on the back of the lower one. Three months had elapsed, and there was much formation of new bone, especially in front of the fracture. The patient declined any further treatment.

The important lesson of the case is obvious; reduction should have been carefully secured (under an anæsthetic if found needful) in the first instance, and the limb secured in a rectangular back splint. The fracture being almost transverse, there might easily be much difficulty in securing complete re-apposition in the first instance. If once obtained and the broken surfaces brought end-to-end there would be but little risk, with proper splintage, of recurrence of displacement.

From the Jones-Morgan Collection.



Bale and Danielsson, Ltd., London.

PLATE F.

RECENT TRANSVERSE FRACTURE OF HUMERUS.

This portrait shows the relative position of the bones in a recent fracture of the shaft of the humerus three inches above the elbow. The fracture is transverse; the bones overlap with an inch of shortening. In a transverse fracture of this kind, if, under efficient extension, the broken surfaces were once brought end to end over a considerable area, there would be no tendency to redisplacement so long as the limb were carefully kept straight. They would prop each other, and it might need considerable bending to again cause them to overlap. Such bending should be easily prevented by splints. At the same time it is obvious that, although the length of the limb might seem to have been gained by extension, so long as the surfaces were not actually in apposition no splints could prevent the recurrence of the displacement. Absolute and unmistakable end-to-end reduction would be the essential of success, and without it all attempts at adjustment by pressure would be useless.

A long hollow rectangular splint for the back of both upper and forearm, with a short straight splint in front of upper arm would be the best. If any uncertainty as to reduction were felt, wiring should be resorted to.

From the Jones-Morgan Collection.

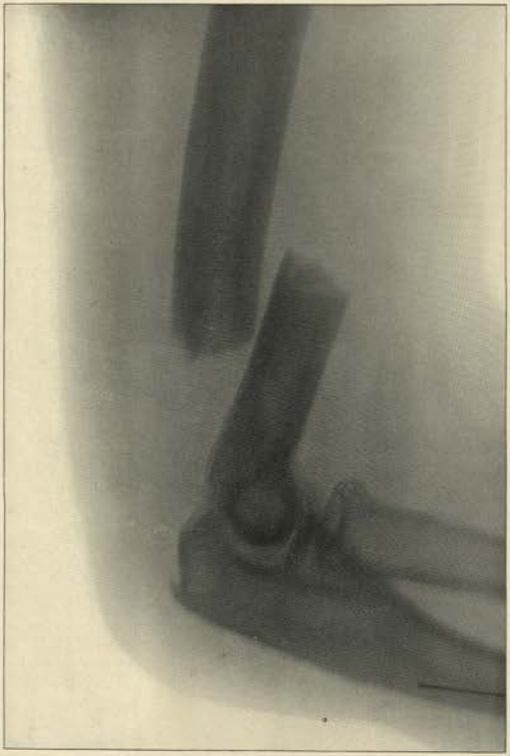


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PLATE G.

FRACTURE OF BOTH BONES OF FOREARM.

In this instance both bones of the forearm have been broken transversely at the junction of middle with upper third. They have been reduced so as to rest end-to-end, the reduction being accurate in the case of the radius, and less so in that of the ulna. Union is in forward progress (tenth week), and, in the instance of the ulna, long splints of ensheathing callus are seen. In the radius there is little more than a ring of callus. The difference as to amount of callus is, no doubt, to be explained by the fact that the periosteum from the end of the ulnar fragments must have been more extensively detached. The relative position of the fragments shows that this must have been so.

From the Jones-Morgan Collection.

Bale and Danielsson, Ltd., London.

PLATE H.

FRACTURE OF BONES OF FOREARM (TEN WEEKS AFTER THE ACCIDENT).

The radiograph of which this is a copy was taken nearly ten weeks after the fracture. The wiring had been done in the third week. The patient was a young adult. It will be seen that the fracture is nearly transverse in the ulna and more oblique in the radius, and that the radius is broken half-an-inch higher up than the ulna. Both bones have been replaced so as to rest end-to-end. Apparently the end-to-end reduction of the somewhat oblique fracture of the radius has caused hyper-extension and held the fragments of the ulna slightly apart. Plates of ensheathing callus are dimly but distinctly seen along the sides of the several fragments. It would appear that the forearm was not quite straight.

From the Jones-Morgan Collection.

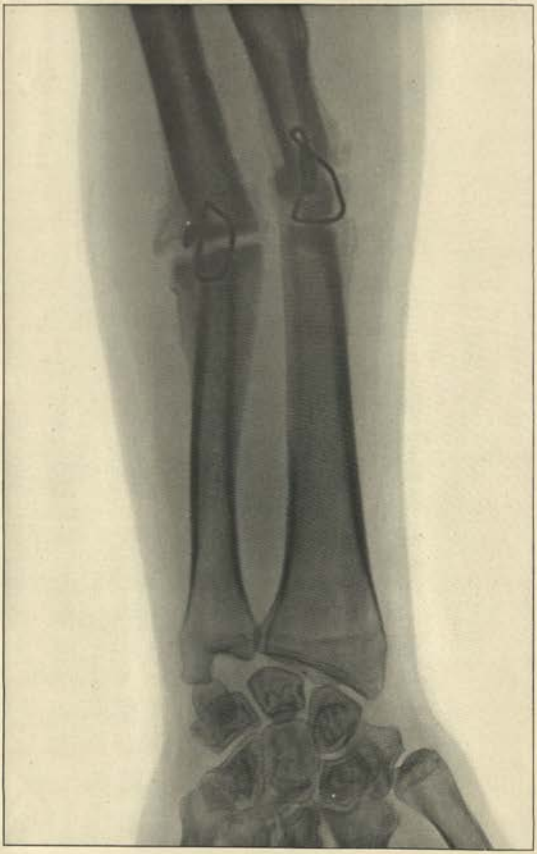

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PLATE I.

MULTIPLE FRACTURE OF BOTH BONES OF FOREARM.

In this instance the fractures were caused by the arm being caught in a wheel. The shaft of the radius is broken nearly four inches above the wrist, in a short transverse spiral, and there is overlapping of fragments to the extent of nearly an inch, with displacement towards the ulna. The ulna has sustained a double fracture lower down than that of the radius and a middle fragment, more than an inch in length, has been completely detached. The sharp lower end of the upper fragment has almost penetrated the skin. The radiograph was taken soon after the accident, and is from the arm of an adult man.

Efficient extention and straight, broad, well-cushioned splints are obviously the measures indicated.

From the Jones-Morgan Collection.

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PLATE J.

CONGENITAL ABSENCE OF CARPAL END OF THE ULNA.

No defect in the bones of the carpus or hand is shown. There is an inch space between the pointed extremity of the deformed ulna and the carpus. The lower fifth of the ulna is wanting, the shaft ending in a point. The shaft is irregularly thickened. The radius is strong and is curved. There is an exostosis, from the inner aspect of the humerus, from the upper part of its middle third, partly a rounded elevation, and partly a long splint projecting downwards. The humerus is slender and its head is small.

From the Jones-Morgan Collection.

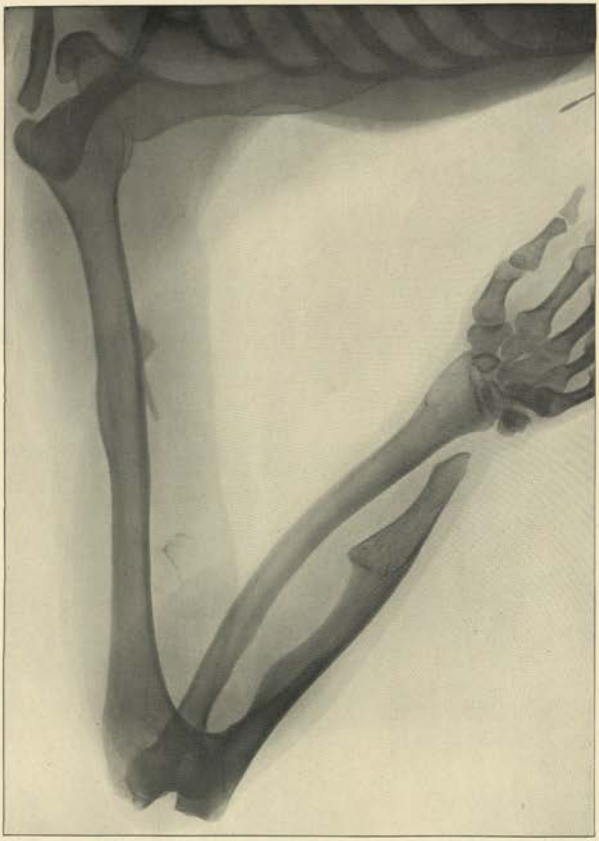

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PLATE K.

PARTIAL DISLOCATION OF THE FOOT BACKWARDS WITH FRACTURES.

In this radiograph the outer malleolus of the tibia is seen to have been detached by a split passing vertically up the tibia. It has with the fibula retained its attachments to the tarsus, and with the whole foot has passed backwards, whilst the lower end of the tibial shaft has passed forwards on the astragalus. The detached malleolus includes nearly half of the articular surface of the tibia. The fibula has given way a little above the middle of its shaft, and is bent inwards at the site of fracture without overlapping. No doubt the fibula gave way after the displacement of the foot, and in consequence of it. The violence was of course indirectly applied, the patient, an adult man, falling on his foot. The aim of treatment would be after complete reduction to prevent reproduction of the displacement. This would be certain to occur if the foot was in any degree pointed, and would be best prevented by putting the limb into a plaster case, with the foot at right angles to the shaft, or bent somewhat forwards. A long plaster case would secure quiet to the calf muscles, which would otherwise prove the agents of displacement, and would obviate the necessity for division of the tendo-achillis.

From the Jones-Morgan Collection.

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CORRESPONDENCE, ADDENDA, &c.

The Spirochæta Pallida discovered in "Yaws."

The first fasciculus of our Clinical Atlas was devoted to the illustration of the disease known in Ceylon as "Parangi." Whilst affording to the reader the fullest opportunity for forming his own opinion no secret was made of the Editor's conclusion that the conditions which had received this name were identical with syphilis. Parangi in Ceylon is the same disease as that known as Yaws in the West Indies and some other regions, and all the statements which can be established respecting the one are true also of the other. Observations are now announced from Ceylon that a Spirochæte, not distinguishable from that of syphilis, has been discovered in the lesions of Parangi. This discovery, if substantiated, will carry conviction to many minds which find difficulty in the estimation of merely clinical evidence. The observer is Dr. Castellani, of Colombo.

Fractures of the Coronoid Process.

Helferich's treatise on Fractures and Dislocations, which constitutes Volume CLXVII. of the New Sydenham Society's series, is profusely illustrated. It does not, however, contain any radiographic illustration of detachment of the coronoid process of the ulna. Nor has any such illustration been as yet placed at the disposal of our Committee. We shall be much obliged to any member who may be in a position to supply one. The figure given by Helferich, fig. 4, plate XLII., is designed only to show the influence of the brachialis anticus in displacing the fragment, and consequently does not represent any dislocation backwards, although he is careful to state that this fracture is usually a complication of such dislocation.

When a dislocation backwards at the elbow can be easily reduced, but also recurs easily, the surgeon naturally suspects injury to the coronoid process. It is this strongly-projecting bone which gives strength to the joint and makes dislocation difficult. The radius also taking support against the capitellum of the humerus does also something, but if its ligaments have once been torn, as they necessarily would be in a dislocation, it can offer but very little impediment to reproduction of the displacement. It is the coronoid process which really constitutes the greater sigmoid notch, and it is practically this notch which constitutes the elbow joint. It would appear, however, that fractures of the coronoid are rare. Conclusive evidence of its existence in cases which never came to a dissection are rare, and museum specimens after dissection still more so. Messrs. Flower and Hulke in their article on "Injuries to the Upper Extremity," in *Holmes' System of Surgery*, have the following remarks:—

"The cases that have been reported in which it has been observed in the living subject are all more or less unsatisfactory." . . . I have been able to meet with but three or four specimens and recorded post-mortem examinations of this injury. . . . Dr. F. H. Hamilton, after a careful analysis of all the published cases, arrives at the conclusion that this injury is extremely rare." Page 790, Vol. II.

This is precisely one of questions upon which radiographs may throw important light.

Lichen Urticatus, or Flea Bites?

We have received the following letter from Dr. Colcott Fox:—

"DEAR SIR,—The Atlas hardly lends itself to a prolonged discussion on the etiology of *Lichen urticatus*, but, if you can find room, I should like to remark on one statement made by your correspondent. In commenting on Plate 156, he says that many of the congestive maculæ show the central *puncture* of flea bites. I beg to say that they do not show the hæmorrhagic punctum of the typical flea bite, but simply a prurigo-like papule.—Yours faithfully, T. COLCOTT FOX."

Whilst in agreement with Dr. Fox in not thinking prolonged discussion on a general question suitable for the Atlas, the Editors yet deem it very desirable that the clinical lessons suggested by our plates and case-narratives should be brought out in fullest possible manner. For any comments upon these our "Correspondence" page will always be open.

Albinism and Loss of Hair: A Correction.

We regret to find that in commenting on the plate showing albinism in two Indian children (see Plate D, Fascic. XX.) we were in error in assuming that the patients were congenitally bald. The removal of hair was artificial. We are indebted to Major Grayfoot, of I.M.S., for this correction, as also for the original photograph.

AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY AND PATHOLOGY

CHIEFLY FROM ORIGINAL SOURCES.

FASCICULUS XXIV. ter, OR XVIII. OF NEW SERIES.

ELEPHANTIASIS IN ENGLISH PRACTICE

AND OTHER SUBJECTS.

ROYAL ASIATIC

PLATE A.—Elephantiasis in English Subjects. "The Barbadoes Leg."
" B.—Elephantiasis of lower extremity in Englishmen (three cases).
" C.—Elephantiasis of lower extremity (two cases).
" D.—Elephantiasis of lower extremity in a woman.
" E.—Elephantiasis of Scrotum in two Englishmen.
" F.—Elephantiasis of Scrotum after Gland disease.
" G.—Elephantiasis of Scrotum after Gland disease.
" H.—Lupus Vulgaris on both Cheeks.
" I.—Morphœa Herpetiformis affecting the frontal nerve region.
" J.—Morphœa Herpetiformis affecting the frontal nerve region.
" K.—Vaccination Sore on Cheek.
" L.—Fracture of Bones of Forearm.
" M.—Rodent Ulcer on both sides of Face.
" N.—The Potato-like Tumour of Neck (two portraits).
" O.—The Potato-like Tumour of Neck (portrait and microscopic).
" P.—Large Tumour in Neck (three views).
" Q.—Keloid on Scar of Burn from Acid.
" R.—Schistosoma Cattoi (Figs. 1 to 5).
" S.—Schistosoma Çattoi (Figs. 6 to 9).

LONDON:

THE NEW SYDENHAM SOCIETY.

THE series of Illustrations now given is one which might have been much extended. It is offered in proof that cases in no respect differing from Tropical Elephantiasis are met with in English practice. The disease is shown to affect in some cases the scrotum, and in others one or both of the lower extremities, and to attain in its ultimate developments conditions which could not easily be surpassed in the Tropics. As a corollary the conclusion appears to be justified that the presence of the *Filaria sanguinis* is by no means essential to the malady, and quite possibly of no great importance. The conditions which alone appear to be essential are lymphatic obstruction and the occurrence of repeated attacks of inflammation of the part, not to be distinguished from recurring erysipelas. Very frequently the first onset is recorded as an attack of erysipelas attended by swelling, and caused, it may be, by the infection of some slight wound or abrasion. Only in exceptional cases is there any enlargement or inflammation of the lymphatic glands, the changes occurring rather in the lymph spaces and trunks. The *rôle* of the filaria would appear to be restricted to the obstruction of the lymphatics, whilst it is well known that it may often be present in great numbers in the blood without displaying any activity whatever in this direction. In India and elsewhere, where elephantiasis is common, the filaria is almost always found, but there are plenty of persons quite free from elephantiasis, and apparently in good health, who are infested by it.

Our series of cases is of value, not only in demonstrating the fact referred to, one often overlooked by tropical observers, but it also places the true pathology of the disease in an instructive light. Cases in which elephantoid conditions are threatened are probably far more common in British practice than they are supposed to be. In many the disease is prevented from progressing by early and judicious treatment. The name "elephantiasis" is bestowed only upon aggravated and neglected cases. In early stages, rest, bandages, and cold lotions, with quinine and steel internally, may often succeed in preventing further progress, and thus, so to speak, obviating the diagnosis. It becomes, therefore, of great importance that early stages of this formidable malady should be promptly recognised, and that a knowledge of these risks should lead to correct and persevering treatment.

PLATE A.

THE BARBADOES LEG—ELEPHANTIASIS ARABUM.

We give by way of introduction to the series illustrating the disease in English patients, a single example of the well-known tropical form. It is offered by way of comparison, for although it exhibits an unusual bulk, even for a Barbadoes case, it will be found to be equalled, or almost so, by some of those which are to follow. In all its features there is also a close correspondence between the tropical and the British cases. It will be observed that in both it is the rule for one limb to escape wholly, a proof that the causation is local. In both, the part of the limb continuous with the main growth is involved in solid œdema; thus the thigh as shown in the plate is twice as thick as that of the other limb. The toes, themselves, as is seen in several of the plates which are to follow, are not involved in the swelling.

The plate is copied from a photograph supplied by Dr. Archer, of Barbadoes, under whose care the patient was.

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PLATE B.

ELEPHANTOID HYPERTROPHY OF ONE LOWER LIMB WITH LYMPHORRHŒA IN THE THIGH.—ELEPHANTIASIS OF THE LOWER EXTREMITY IN AN EARLY STAGE.

In Fig. 1 we have a copy of a photograph showing elephantoid œdema with hypertrophy of the whole of one lower extremity in a young girl. The patient was sent to the Polyclinic in June, 1902, by Dr. Fisher, of Tiverton, but she had previously been under observation and treatment at several Metropolitan hospitals. The girl was then 14 years of age, and the history given was that the swelling of the limb had commenced six years or more before without any recognised cause. From the beginning the child had been liable every few weeks to attacks of slight illness attended by much increase of swelling and by the oozing of considerable quantities of milky fluid from some little vesicles which were persistent on the upper part of the thigh. The swelling involved all parts of the limb, even the toes, but was greater in the leg than thigh. The skin was tense and firm and somewhat nodulated in places. The photograph shows two long scars on the inner aspect of the thigh separated by a narrow band and surrounded by lymph vesicles and small keloid nodules. These scars, which were themselves in a state of keloid, were the result of an operation for the removal of skin which had been performed two years previously. No enlarged lymphatic trunks could be traced nor were any enlarged glands obvious.

The patient was subsequently under care in the London Hospital. The presence of lymphorrhœa as a complication has been noted in other cases.

CASES OF ELEPHANTIASIS OF THE LOWER EXTREMITY IN AN EARLY STAGE.

Fig. 2 is from a photograph taken many years ago of a patient who was repeatedly under observation at the London Hospital. His left leg was gradually passing into a state of elephantoid hypertrophy and he was liable to recurring attacks of inflammation, attended by much temporary increase of swelling. He was always much benefited by rest and bandaging.

Fig. 3 is from a similar case to Fig. 2, with the difference that a chronic ulcer was present in the middle of the leg. It may be noted that in many cases of chronic ulceration some degree of elephantoid œdema is present. These cases are not, however, as a rule, liable to attacks of erysipelatoid fever and inflammation.

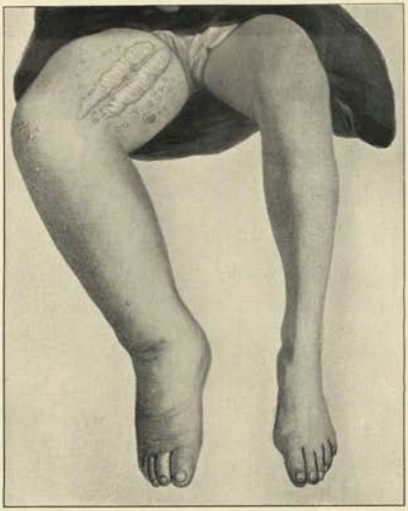

FIG. 1.

FIG. 2.

FIG. 3.

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PLATE C.

ELEPHANTIASIS OF THE LOWER EXTREMITY IN ENGLISH PATIENTS.

Fig. 1.—From a photograph taken in 1887 of a patient under the care of Mr. Page, of Newcastle. The patient, a young adult Englishman, was the subject of elephantoid hypertrophy of the left lower extremity. The foot itself was involved in solid œdema. The swelling of the limb was stated to have commenced in early childhood.

Fig. 2.—From a photograph given to the writer in 1870 by Dr. Isaac Smith, of Fall River, U.S.A. The case is reported in the *American Journal of Medical Sciences* for July, 1870, page 119. The circumference of the calf was 3 feet 1 inch.

The patient was a woman, aged 50, of English parentage and born in England. She had borne nine children, and during each of her last two pregnancies considerable swelling of the left lower limb had occurred, but this had cleared away after her confinements. The beginning of her present malady was an attack of "erysipelas," which occurred about six years before the state was assumed which is represented in our plate. After this attack the foot remained swollen, and steady increase in bulk followed. During the last year the temperature of the limb had been very variable, sometimes very cold, but more frequently "at a high degree of excitement, and always very sensitive to the touch." The formation of a large abscess in the upper part of the leg, and the drain which resulted from it, had very nearly resulted in death. She recovered, however, from this illness, and a year later, at her own urgent wish, amputation was performed. Although not much blood had been lost, the shock was such that she sank within an hour of its completion. Examination of the limb after amputation was made by a distinguished pathologist, Dr. J. C. Warren, of Boston. He reported dense fibrous induration of the subcutaneous tissue, making it impossible to distinguish the limitation of the cutis vera. The papillæ were much larger than normal, and both blood-vessels and lymphatic tubes were thickened. The special gland organs of the skin were almost wholly lost. The whole limb weighed a trifle more than 100 pounds avoirdupois.

It will be seen that in this case the disease was supposed to have been initiated by an attack of "erysipelas," and although that word is not mentioned in the subsequent narrative, there can be little doubt that the recurrent inflammations of the limb, attended by heat and fever, were of that nature.

Fig. 2.

Fig. 1.

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PLATE D.

ELEPHANTIASIS IN ADVANCED CONDITION IN AN ENGLISHWOMAN

This portrait is reproduced from a lithograph given in vol. xxx. of the *Guy's Hospital Reports*. It is that of a woman who was the subject of very advanced elephantoid hypertrophy of the right lower extremity.

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PLATE E.

ELEPHANTIASIS OF THE SCROTUM IN ENGLISHMEN.

Fig. 1 represents a large scrotal elephantiasis in an Englishman. It is stated that its weight after removal was more than 44 pounds.

Fig. 2.—This figure is copied from a plate given by the late Mr. John Wiblin, of Southampton, in vol. xlvi. of the *Medico-Chirurgical Transactions*. It represents a large elephantiasis tumour of the scrotum with a clamp in position as it had been devised for operation.

The patient was a man, aged 40, a native of Southampton, who had been a dock labourer and also engaged in the coasting trade, but who had never (it is presumed) visited the Tropics. He had been the subject of double inguinal hernia for eighteen years, and during the early part of this period had worn a double truss. Fourteen years ago he had contracted syphilis, but under prolonged and energetic treatment by mercury had apparently quite recovered from it. The commencement of his elephantiasis dated, however, from within a few months of this illness. Of late years he considered that he had been in good health, but during the last two the size of the tumour had greatly increased, and much inconvenience from ulceration, &c., had been caused. Mr. Wiblin brought the patient up to London, and for a few days he was an inmate of King's College Hospital in order to allow opportunity to the profession to inspect a very unusual case. Every precaution that ingenuity could suggest was adopted in preparation for the operation, and on September 21, 1861, Mr. Wiblin (assisted by Mr. Spencer Wells, Henry Smith, Carr Jackson, and others) undertook the excision. The clamp having possibly been inaccurately applied, the left hernial sac, containing several coils of intestine, was opened and the testicle wounded. It was found impracticable to return the intestine, but the excision was completed and the wound in the sac stitched up. Symptoms of obstruction followed the operation and the patient sank on the fifth day. The contents of the sac were found inflamed, and in parts gangrenous. At the time that Mr. Wiblin undertook this bold operation none of similar dimensions had ever been attempted in England. In India, Dr. Goodwin, Dr. O'Brian, Mr. Godfrey and Dr. Esdaile had operated in many cases, and about the same time Dr. (now Sir Joseph) Fayrer published his well-known paper describing various improvements in the details of procedure. It is not intended on the present occasion to deal with these and other advances in treatment, but we cannot forbear to remark that the present race of Indian surgeons have brought the operation to such perfection that the most formidable cases are now daily undertaken with very little risk to life. It was obviously the unfortunate ill-adjustment of the clamp which led to Mr. Wiblin's disaster. The modern method of operating as now practised in Madras, Calcutta, and other Indian cities, will be illustrated in a future Fasciculus.

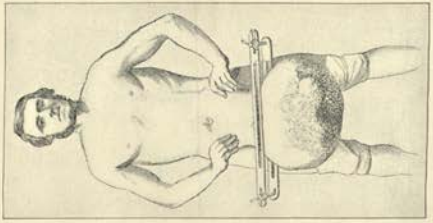

FIG. 2.

FIG. 1.

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PLATE F.

ELEPHANTIASIS OF THE SCROTUM IN AN ENGLISH PATIENT WHO HAD PREVIOUSLY SUFFERED FROM EXTENSIVE GLAND DISEASE.

Fig. 3.—This figure is from a photograph of a patient who attended at one of Mr. Hutchinson's lectures at the Polyclinic in July, 1905. It is of great interest not only as an example of well-characterised scrotal elephantiasis in a man who had never left England, but because the condition had been preceded by extensive disease of the lymphatic system. The patient was a young man, aged 22. His neck and groins were extensively scarred as the result of abscesses. He had been an inmate of many hospitals. On several occasions glands had been excised and abscesses opened and scraped. In consequence, as is suggested, of obstructive inflammation of the lymphatics in the groin, and repeated attacks of erysipelatoid inflammation, the scrotum had passed into the condition here shown. There were numerous lymph-tubercles on the sides of the thighs and scrotum, and from some of these there had often been lymph discharges. There had been periodic attacks of inflammation attended by fever. The young man was pale and much out of health. Circumcision had been performed. The scar and the adjacent skin of penis were much thickened.

After this photograph was taken the patient was admitted into the London Hospital for operation. Excision was performed and he recovered sufficiently to leave the Hospital for a convalescent home, but he died in the latter institution. The wound was well healed before he left the Hospital.

In this case, as in the subject of Plate B, we have the occurrence of lymphorrhœa in the groin as a complication of elephantiasis. It is probable that much of the rounded swelling was due to inflammatory hydrocele, which is a common coincident condition in these cases.

There was a condition of brawny œdema of both thighs. The thickening of the scrotal tissues was still aggressive, as also the œdema of the thighs. (See next Plate.)

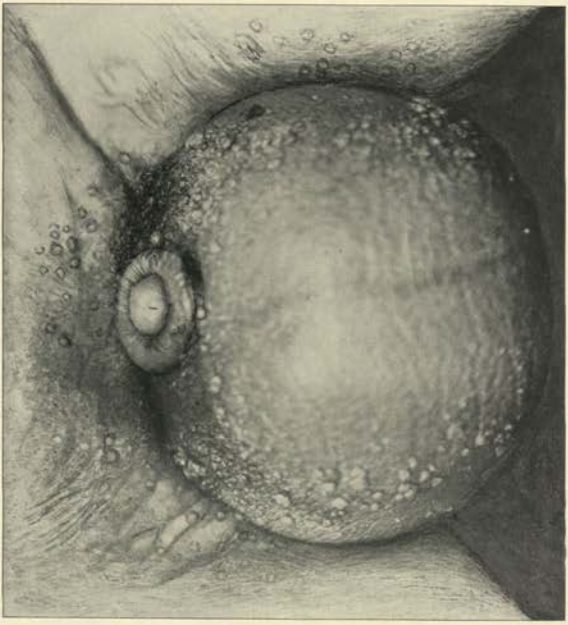

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PLATE G.

ELEPHANTIASIS OF THE SCROTUM AFTER DESTRUCTIVE DISEASE OF GLANDULAR SYSTEM.

This portrait is from the same case as that illustrated in the preceding portrait. It is given because it shows well the extensive scars resulting from the abscesses in the femoral and inguinal glands and the operations which had been performed. It is especially desired to draw attention to the fact that the elephantoid changes were secondary to destruction of the lymph-channels.

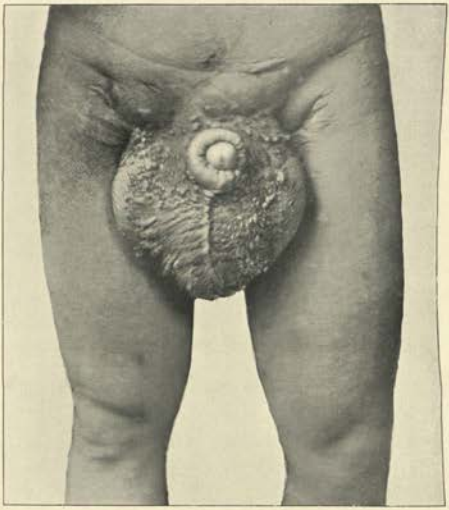

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PLATE H.

LUPUS VULGARIS OCCURRING WITH BILATERAL SYMMETRY.

The rarity with which lupus vulgaris is developed with bilateral symmetry has often been commented on. Very often it occurs as a solitary lesion, and when there are more patches than one they are almost invariably placed as if by accident here and there and not on corresponding parts of the body. It has been suggested that this is to be explained by supposing that the original lesion is usually traumatic and that the subsequent ones result not from blood contamination but from the transference of infective material by the patient's finger-nails. This hypothesis receives some support from the facts observed in what is known as multiple lupus, in which the patches are very numerous. In these cases the multiplicity is almost invariably attained in the earliest stage of the disease at a period when inflammatory elements are freely produced. At this stage the crusts which cover the patches consist chiefly of dried pus and they so effectually conceal the characters of the disease that the diagnosis is often missed. After a few months the inflammatory conditions come to an end and with them all tendency to the production of fresh patches. Very probably many of those which attended the outbreak may meanwhile have soundly healed under simple measures of treatment. These never afterwards show any tendency to relapse, and those which remain settle down, into the chronic stage of lupus-growth attended for the most part by but little tendency to inflame or to acquire pus-crusts. They may now, unless cured by vigorous treatment, last a lifetime, continuing slowly to extend at their margins and to produce satellites, but never evoking new patches on other parts of the body. These facts suggest that the initial stage is sometimes attended by cell elements which are virulently infective and that the tendency to their production soon ceases and never recurs. The contrast between lupus vulgaris and lupus erythematosus in these features is very marked. The latter almost invariably develops with definite bilateral symmetry and shows at first no tendency to aggressive outbreak, but becomes more extensive and severe as time advances, until in the lapse of years it may undergo spontaneous cure. Inasmuch as the absence of bilateral symmetry in lupus vulgaris is probably dependant upon accident we may be prepared to expect exceptions to the usual course. There is no reason why accident should not occasionally plant the lesions on corresponding parts of the surface. A good example of this exceptional symmetry is afforded by Plate H. The two figures are from portraits kindly supplied by Dr. Arthur Hall, of Sheffield. The patient was a woman, aged 49. The disease on the right side began after the birth of her first child, twenty-six years ago, and that on the left a little later. She had had much treatment and excisions with subsequent grafting had been practised on the right side repeatedly, but not with very good results. It will be observed that the patches are placed almost exactly on corresponding parts and are much alike. Close inspection will, however, show that the patch on the left side looks much flatter and thinner than that on the right. This was attributable to the good influence of light treatment which had been employed for eight months before the photographs were taken. The patient had lost a brother and a sister from tuberculous affections.

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PLATE I.

MORPHŒA HERPETIFORMIS AFFECTING THE TERRITORY OF THE FRONTAL NERVE.

The Plate is copied from a photograph kindly supplied by Dr. Unna, of Hamburg. It exhibits with beautiful distinctness a broad linear patch of parchment-like skin resulting from morphœa, affecting the region supplied by the supra-orbital nerve. The patient was a young woman, aged 21. It will be seen that the patch divides into two arms as it passes upwards and on these tracts the hair has been lost. In these cases the area involved is precisely the same as that in Herpes frontalis, and in different cases similar differences are observed as to the extent involved. The distribution is always determined by twigs of the nerve, and both in herpes and morphœa the greatest severity is usually just above the eyebrow and near to the middle line. In many cases this nerve is affected in company with other branches of the fifth, but in some cases, as shown in this and the next plate, it suffers alone.

The reader may refer with interest to Fasciculus XIX., Plates C., C. bis., E. and I., in which parallel conditions are displayed. In these, however, as is usual, the morphœa changes occurred on other regions as well as the forehead. The affection known as Hemiatrophy of the face is usually a consequence of morphœa affecting the whole of the fifth nerve territory and occurring in early life.

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PLATE J.

MORPHŒA HERPETIFORMIS AFFECTING THE FRONTAL NERVE TERRITORY.

This portrait, like the preceding, is from a photograph supplied by Dr. Unna. Like it, it exhibits a deep furrow passing vertically up the right forehead not far from the median line. The patient was a boy, aged 9, in whom the original attack had occurred more than three years before. On both sides of the furrow and on the scalp above it the skin was in a parchment condition.

In Dr. Radcliffe Crocker's Atlas a good portrait showing the furrow which these Plates illustrate may be found. It is a well-known condition.

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PLATE K.

ACCIDENTAL INOCULATION OF AN ACNE PUSTULE WITH VACCINE.

———

In the case which is represented in our Plate, a married woman had accidentally inoculated a small pustule (which had been for some time present on her face and which she had been in the habit of picking) with the lymph from her own infant's vaccination. The infant was vaccinated on April 17, and on April 24 its arm was much inflamed. On April 28 the mother noticed that the spot on her cheek was very red; on the following day "it appeared to have matter in it," and on May 2 "it broke." It was not till May 4 that she obtained advice, and the sore then presented the conditions shown in the Plate. There was much swelling of the adjacent parts of cheek and neck, and some enlargement of the lymphatic glands. In the course of a fortnight under treatment with boric acid dressing the sore had healed and no ill results followed.

This portrait is not given as an illustration of what is usual in accidental inoculation with vaccine lymph. The appearances presented were very unusual, and much difficulty was felt in the diagnosis before the history was made out. The peculiarities may be supposed to have been in part due to the circumstance that the structure inoculated was probably a sebaceous gland already in a state of inflammation.

Two published portraits may be referred to as showing appearances very similar to those in this Plate. One is given as Plate 18 in Hutchinson's "Smaller Atlas," and was from a man who was treated in the London Hospital. He was a horse-keeper, and it was thought possible that the inoculation came from "grease" on the heels of a horse. The other is given in a paper by Mr. Langton, in the *Transactions of the Clinical Society*. Mr. Langton's patient was, like the preceding, a horse-keeper, and had been engaged in dressing the heels of horses affected with "grease." In both of these instances there were several sores, and in both the healing was satisfactory under simple treatment. It will be remembered that Jenner asserted a connection between "grease" in horses and variola in cows. The close resemblance of the sores in the two cases referred to with that of the present Plate will strike any one who may take the trouble to look them up.

The diagnosis in these cases is both important and difficult. At first sight such a sore as that presented in our Plate is suggestive of either primary chancre or malignant pustule, much rather than of vaccination. The same remark applies to the other two cases cited, although in them the multiplicity of the sores was opposed to these suggestions. In all the cases the absence of the ring of secondary vesicles so often seen at the margin of a malignant pustule afforded valuable evidence.

The case illustrated in this Plate occurred in the practice of Dr. Ringrose, of Newark, to whom the Atlas is indebted for both the photograph and the facts. In Fig. 2, Plate A, Fasciculus XVII. of the present Atlas, an illustration of multiple vaccination sores on the hands of a nurse may be referred to. In this instance the results were typically umbilicated vesications.

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PLATE L.

CROSS-UNION OF THE BONES OF THE FOREARM AFTER FRACTURE.

This radiograph is given as a warning against the careless application of splints in fractures of the bones of the forearm. These are the only bones in the body in which injurious cross-union is possible, and the utmost care should be taken in order to avoid it. In the present instance it had occurred. The rules for treatment are simple. The most important of them is to avoid any lateral constriction of the limb. The splints should be wide enough to project well at the sides and the cushions should be rather less wide and should be soft. The effect of bandaging under such conditions is to press the soft parts between the bones, to somewhat flatten the forearm and to keep the bones well apart. The forearm should, of course, be in complete supination, in reference to which surgeons of a bygone day had a vulgar but very expressive direction which we need not quote, as it is well known. In the present instance it would appear that these rules, or some of them, had been neglected. The forearm had evidently been constricted. The patient came under the observation of Mr. Ashby Osborn, of Dover, two months after the fracture. We are indebted to Mr. Osborne for the radiograph.

It is scarcely necessary to add that in the first setting of such fractures the extension should be efficient. In this instance the overlapping had not been wholly removed.

Bale and Danielsson, Ltd., London.

PLATE M.

RODENT ULCER OCCURRING ON BOTH SIDES OF THE FACE.

This portrait, copied from a photograph supplied by Dr. Arthur Hall, of Sheffield, illustrates the occurrence of the Rodent ulcer on both sides of the face. The patient was a woman near 50, and the ulcers were of long standing. On the right side the temple is affected and on the left the lower eyelid. The sore on the temple had been present much longer than the other, and already showed cicatrisation over parts of its surface. On other parts the rolled edge was very characteristic.

Although the Rodent ulcer is usually solitary, examples of multiplicity are by no means uncommon. They occur almost invariably on the faces of those well advanced in years, and are proofs of the proclivity of the senile skin to the cancerous forms of growth. On the faces of old men, especially those of florid complexion and somewhat delicate skin, it is not very uncommon to see a number of little patches which are persistent and slightly scaly, and which illustrate the precancerous stage. Some of these may pass into rodent ulceration, others assume the condition of the crateriform ulcer, and others, again, take on papillomatous growth. Under suitable treatment many may disappear. In cases of well-pronounced rodent ulcer very often there are other patches which are more or less doubtful. They are almost always scattered irregularly and scarcely ever located with bilateral symmetry; of this absence of symmetry Dr. Hall's case affords an example.

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PLATE N.

THE "POTATO-LIKE TUMOUR" OF THE NECK.

An important paper by Mr. Hastings Gilford, of Reading, has appeared in a recent number of the *Practitioner*, concerning the peculiar tumour of the neck to which the epithet "potato-like" had been temporarily applied. It had not, in the first instance, been definitely separated from the lympho-sarcomata, but Mr. Gilford believes that he has obtained facts which show that it begins in the carotid body and is an endothelioma. We now republish the original illustrations as given in the *Illustrated Medical News* of October, 1888, and by the kind permission of the proprietors of the *Practitioner* reproduce also those given with Mr. Gilford's paper. These latter include some from the microscope. These are especially valuable, because at the time of the first clinical description of the peculiarities of this tumour no opportunities had been utilised for procuring delineations of the histological structure, although several examinations had been made.

We quote the following from Mr. Gilford's paper:—

In 1888, an account in the *Illustrated Medical News* was published of some instances of a peculiar growth springing from the upper third of the anterior triangle of the neck. Of this growth the writer says:[1] "It has no connection with the parotid or face, but grows under the sterno-mastoid. From beneath that muscle it pushes its way both behind and forwards, and assumes the shape of a huge kidney potato. It can never at any stage be recognised as consisting of separate glands, and it seldom shows any tendency to implicate or cause enlargement of adjacent glands, but having once begun, it grows rapidly as a continuous, very firm, nodular mass. From its form and its hard nodosities I have been in the habit of calling it "the submastoid potato tumour." Its growth is usually so rapid that it produces death within a year or eighteen months from its beginning. It brings about death by its growth, its pressure upon adjacent parts, and by the bleeding and discharges which attend its ulceration. So far as my knowledge extends there is no tendency to the production of secondary tumours. I have seen at least eight examples of it. . . . In several cases portions removed for microscopic examination have been pronounced 'round-celled sarcoma,' or 'lympho-sarcoma.' I am not familiar with any growth of quite parallel clinical history in any other region. . . . It may be conjectured that it begins in the submastoid glands, but if so, it is very remarkable that neither can its gland-enlargement stage be recognised, nor does it spread to the glands. Nor must it be forgotten that cystic tumours also are sometimes developed in this precise situation. On the supposition that it begins in lymph glands, it is further very difficult to account for the fact that it always forms under the upper third of the muscle, never lower down."

In another case, reported six weeks later, the tumour was treated with Bougard's Vienna paste, after the injection of cocaine, with excellent results, though the tumour was a large one. It was apparently destroyed, but came back in four months. The length of time before recurrence took place must be regarded as very encouraging, considering the malignancy of these tumours.

The occurrence of these growths in one particular region of the neck and in no other part of the body suggests that they must spring from some structure which is peculiar to this area. We at first supposed that they had their origin in some vestige of embryonic tissue persisting in the neighbourhood of a branchial cleft. But, in that case, it would be very unlikely that the tumour would always spring from one spot; and, moreover, a growth springing from an epithelial vestige would probably be an epithelioma. But Captain Finch, of the Polyclinic, after examining one of the growths about to be described, pointed out that it was not an epithelioma but an endothelioma. In none of these cases was there any structure resembling the cell-nests of an epithelioma.

After mentioning that other forms of malignant growth taking origin in the neck had been described by Volkmann and others under the name of branchioma, Mr. Gilford proceeds to state that to Marchand belongs the credit of first suggesting that the special form with which we are now concerned takes its beginning in the carotid gland itself. He writes:—

The exact origin of these growths was first pointed out by Marchand,[2] who gives a detailed description of the embryology and anatomy of the "gland." He describes a tumour in a woman, aged 32, which had been diagnosed as a lymphoma, but was found to originate at the fork of the carotid, to communicate the pulsations of the artery, and to consist of small vessels, held together by groups of endothelial cells. The fact that the situation of the growth could be traced to the site of the carotid body and that the microscopic structure distinctly resembled that of the normal "gland," led the author to believe that it took its origin from that structure itself.

[1] *Illus. Med. News*, October 13, 1888; also November 3, 1888.

[2] Virchow's *Festschrift*, vol. i., 1891 p. 537.

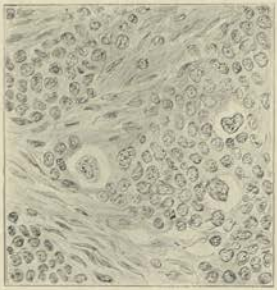

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PLATE N—*(continued).*

Other cases are described by Reclus and Chevassu,[1] who give sketches and descriptions of ten similar growths, which originated within the carotid sheath at the bifurcation of the artery. Some of these are represented as being actually astride the fork of the artery, while another is merely grooved by the carotids so that a shallow tongue of growth projects between the two branches. In the following cases there is no such projection, and the growths are less vascular and much denser. Reclus finds that the tumours are equally common on both sides of the neck, and that they most often occur in middle-aged women. He says that their surgical treatment is attended with much danger.

Mr. Gilford then proceeds to describe three cases which had come under his own observation.

Case 1.—A man, aged 63. Tumour of six months' growth on the left side of neck. In the operation for its removal it was found necessary to excise portions of the artery and vein which were involved in the growth. Death with hemiplegia and pneumonia followed on the seventh day. The potato was surrounded by a well-defined rind, which was composed of tissues pushed aside by and adhering to the tumour. The section was glistening dense pearl-white and seemed to be almost non-vascular. It was of uniform colour and texture except in a few places, where it was softer and darker and appeared to be breaking down.

Case 2.—A man, aged 52, tumour on the left side of neck and of only three months' growth. At the excision it was found to be resting on the carotid vessels at their bifurcation and firmly adherent to the vein. The growth recurred six weeks after the operation, and death followed three months later.

The tumour after excision was described as appearing on section, solid, whitish, and much like a raw potato, It was made the subject of very careful microscopic examination by several skilled observers. Opinions differed somewhat as to details, but concurred in the view that it approached carcinoma much more closely than lympho-sarcoma. Captain Pinch, at the Polyclinic laboratory, regarded it as an endothelioma. It was from this specimen that the illustrations given in Plate N were made.

Case 3.—The appearance of the patient in this case is illustrated in Plate N. The patient was a man, aged 74, in whom the tumours had been growing for about a year. A remarkable and exceptional feature was, that they occurred on both sides. Operation was out of question. After death a careful dissection was made, for details of which we must refer to the *Practitioner*. There were growths in the liver but none in lymphatic glands. Mr. Gilford regarded them all as endotheliomata and as having taken origin in the carotid body.

PLATE O.

TWO ILLUSTRATIONS OF THE POTATO-LIKE TUMOUR OF THE NECK.

The two portraits here given are those referred to by Mr. Gilford as the original ones published as illustrating the potato-like tumour. They show well the position and shape of the growth so named. In each case the growth occurred on only one side, and in both it had grown rapidly. Both died not long after their portraits were taken.—See the *Illustrated Medical News*, October, 1888.

The following particulars refer to Fig. 1 :—

The tumour had been growing for nearly a year, and her health was beginning to fail. It had not yet ulcerated, but was threatening to do so. There was no pulsation in the temporal artery above it, making it probable that the carotid was occluded. The pupil was small and motionless, from implication of the sympathetic trunk, and she had also suffered from cough and other symptoms of irritation of the pneumo-gastric. Thus it appeared certain that the tumour was implicating the deep parts.

[1] *Revue de Chirurg.* 1903, p. 149, XXVIII. We are indebted for this reference to the Epitome of the *British Medical Journal.*

Fig. 1.

Fig. 2.

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PLATE P.

LARGE TUMOUR IN THE NECK (Potato-like).

These portraits illustrate very graphically the condition assumed in late stages of the potato-like tumour. In several others, the growth so-named has been seen to obtain a size quite equal to that here shown. The usual termination is by its breaking down, and the production of an enormous sloughing ulcer by which the patient's strength is rapidly exhausted. Such was, it is believed, the course taken in the present instance, but we are not able to offer authenticated details. It will be seen that the front face portrait shows some indications of swelling in the left side of the neck and gives to the patient a general aspect not unlike that of lymphadenoma, or Hodgkin's disease. The preponderance of the growth on the right side is, however, still far in excess of anything usually seen in the latter. If Figs. 1 and 2 stood alone they might be regarded as characteristic of the conditions in an advanced stage of the "potato tumour." The potato-like tumour has in most cases hitherto observed, been restricted to one side, while lymphadenoma, as is well known, usually affects both.

We are not in a position, through want of case-details, to give any positive diagnosis in this instance. It may have been an example of lymphadenoma or lympho-sarcoma. The portraits may still, however, serve as excellent illustrations of what is usual in the growths with which we are dealing.

Whether Dr. Gilford's observation will prove to be correct, that the carotid body is the structure in which the growths which have been called potato-like originate, must be held for the present to need confirmation. The original suggestion was that they were of sarcomatous nature. That they present features of clinical peculiarity, being usually single, of potato-like form, of rapid growth, without tendency to gland affection or multiplicity, is probably all that can at present be asserted with confidence.

Mr. Rushton Parker, of Liverpool, has submitted to the Atlas Committee a water-colour drawing which probably illustrates the potato-like tumour in its late stage. The tumour was on one side of the neck only, and there were no growths elsewhere. The patient was a middle-aged man, in whom the growth had developed rapidly. Softening and destructive ulceration had occurred. Complete extirpation was found to be impracticable. It was diagnosed as a sarcoma.

FIG. 3.

FIG. 2.

FIG. 1.

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PLATE Q.

CICATRICIAL KELOID AFTER A BURN FROM SULPHURIC ACID.

This portrait, copied from one supplied by Dr. Hall, of Sheffield, illustrates the occurrence of keloid after a burn by sulphuric acid. The patient was a lad, aged 18, who had been apprenticed to a chemist. He was burned by the breaking of a bottle containing sulphuric acid. After healing, the scar tissue thickened, and passed into the condition here shown. It is to be observed that there is no contraction of the cheek. The keloid condition is one of growth and never causes contraction.

The accident had occurred three years before the portrait was taken. Attempts had been made to improve the lad's appearance by excision of some of the thickest parts, and subsequent skin grafting, but they had been disappointing on account of recurrence of the growth. It will be seen that in addition to the large keloid scar in cheek there are other smaller ones on forehead, and that both corneæ show leucomata.

The boy complained much of irritability of the scar, and of soreness and pain when exposed to cold winds. In some parts the scar showed tendency to soften and thin.

The form of keloid here illustrated is that best known as "cicatricial," since it appears to be invariably connected with some injury tending to produce scar-tissue. It was formerly known as "false keloid" or "keloid of Alibert." The size of the preceding scar may, however, have been quite insignificant in comparison with the resulting growths. The scars of acne, of boils, of vaccination, or of small-pox, and even of yet smaller lesions, may be followed by large keloids. As a rule, the growths, after a more or less prolonged duration, tend to soften and disappear. The younger the patient the greater is the hopefulness of this result. Excisions are almost invariably disappointing, being followed by fresh growth, and not unfrequently they make matters worse.

The influence of the Finsen treatment, or that by the X-rays, has not as yet been sufficiently tested, but it is probably not hopeful. Patience and the use of some mild ointment, such as the iodide of lead, are probably the best measures, and at the same time arsenic may be administered internally.

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PLATE R.

ILLUSTRATIONS OF THE SCHISTOSOMA CATTOI, A NEW BLOOD-FLUKE OF MAN.

(Descriptions of Plate by Dr. Catto.)

We are indebted to the proprietors of the *Journal of Tropical Medicine* for the use of the blocks which illustrates Dr. Catto's important discovery. The author has himself kindly abbreviated for us the following description :—

This new schistosome, whose habitat is the mesenteric vessels, was found in a Chinaman. It closely resembles *Bilharzia hæmatobia*, but differs in certain important characters. The cuticle of the male is quite smooth, while that of the African worm is provided with ciliated warts. The females resemble one another more closely, but the posterior sucker is larger than the anterior sucker in *Schistosoma cattoi*, whereas the reverse is the case in *Schistosoma hæmatobium*. The ova in the uterus of a female schistosome at once prove the species. The ova of *Schistosoma cattoi* have a smooth shell devoid of spine or operculum. They are more rounded and considerably shorter than the ova of *Schistosoma hæmatobium*, which possess, in addition, either a lateral or end spine.

The ova are found in the fæces of persons infected by this parasite. The disease is evidently also endemic in Japan.[1]

The lesions produced by either schistosome are much the same—coarse hypertrophic cirrhosis of the liver and fibrosis of the various viscera affected by the ova, which are easily demonstrable in sections.

The distribution of the ova in a patient is more widespread in *Schistosoma cattoi* than in *Schistosoma hæmatobium*, while the adults of the former are found in arteries and veins, but the adults of the latter in veins only.

Schistosoma hæmatobium favours the urinary tract ; *Schistosoma cattoi* favours the intestinal tract, though biharziosis, in Puerto Rico, is mostly of the intestinal variety.[2]

Fig. 1.—The submucous coat of the bowel has a large increase in the amount of fibrous tissue. The ova are single, in groups, and a tendency to form rows is seen.

Fig. 2.—Two vessels are arteries and two are veins. Three of the four are occupied by parent schistosomes. In the left vein the fluke is bent on its long axis. By this means it maintains its position against the blood flow.

Fig. 3.—Sections of two pairs of schistosomes lie in an artery. More probably it is one pair coiled on their long axis. The same pair being cut twice looks like two single pairs lying side by side. In the left pair the female lies in the gynæcophoric canal of the male. The female of the pair to the right lies between the male and the vessel wall. In all the intestinal cæca are distinct, while ova are seen in the uterus of the female.

Fig. 4.—Three anastomoses of the intestinal cæca are seen in the male. The black appearance of the cæca is due to a recent meal.

Fig. 5.—As before.

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[1] "*Schistosoma Japonicum*," by Dr. Katsarada, translated by Dr. T. S. Kerr, *Journal of Tropical Medicine*, April 1, 1905.

[2] "Bilharziosis in Puerto Rico," by Dr. G. Gonzalez Martinez, April, 1904.

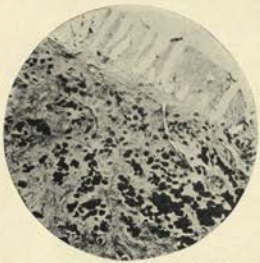

FIG. 1.—Ova in intestinal submucosa. At first taken to be coccidia.

FIG. 2.—Section of mesentery. Worms seen lying in blood-vessels in transverse and longitudinal section. Note difference in thickness of vessel walls.

FIG. 3.—Magnified view of fig. 2, showing transverse section of blood-vessels with worms *in situ*. Note smooth cuticle.

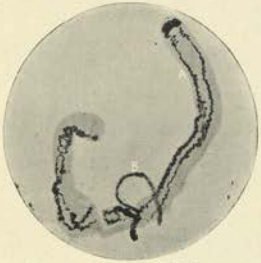

FIG. 4.—Male worm with a portion of female. A, Male worm showing cæca; B, female.

FIG 5.—Male worm. Note smooth cuticle.

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PLATE S.

SCHISTOSOMA CATTOI.

(Description of Plate by Dr. Catto.)

Fig. 6.—The ova are densely packed under the muscularis mucosæ. The muscular coats of the intestine are comparatively free from ova. A possible explanation of this is that the peristaltic action, taking place in these coats, hinders the entrance of, or hastens the progress of, the ova through the longitudinal and circular muscle fibres.

Fig. 7.—The smooth oval shell of the ova and absence of both spine and operculum is characteristic. The contents of the ova stain in different degrees, but in none is any embryo distinct.

Fig. 8.—The mucous coat is, in parts, broken down, as is the muscularis mucosæ. The fibrous tissue in the submucous coat is more marked than in fig. 1.

To Dr. T. S. Kerr and E. E. Henderson I am greatly indebted for the excellent drawing and microphotographs.

Professor Blanchard, to whom specimens were sent for exhibition at the International Zoological Congress, has done me the honour of naming the parasite after me.

FIG. 6.—Section of appendix (stained), showing ova in masses, a dense submucous layer, and a less marked subperitoneal layer.

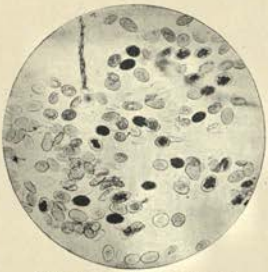

FIG. 7.—Magnified view of fig. 6, showing ova.

FIG. 8.—Ova in process of extrusion from intestinal mucosa.

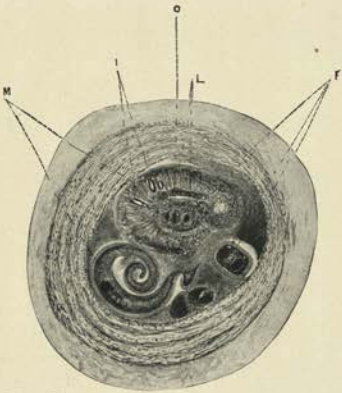

FIG. 9.—Transverse section of a mesenteric vessel showing: M, two male schistosomes; F, females; I, cæca in male; L, cæca in female; O, ovum. Magnification 56 ×.

The Nature and Treatment of "Lichen Urticatus."

(Letter from Dr. Unna.)

We have received from our esteemed Associate, Dr. Unna, of Hamburg, the following important contribution to the discussion on the pathology of "Lichen urticatus." It will be seen that it concerns chiefly treatment and does not express any very definite opinion as to cause. Something may be inferred, however, as to the nature of a malady by observing that of the remedies required. Dr. Unna advocates external measures alone. It may easily be believed, that few measures would be more effectual against the attacks of insects than those which he suggests in the following letter:—

"My Dear Mr. ——,—I thought in former times, like most of my countrymen, that lichen urticatus in children was largely due to intestinal disorders, and therefore for years my treatment in the Polyclinic, where we always have a large number of cases, was partly external, partly internal. Internally, I gave ichthyol, antipyrin and other similar preparations; externally, always a mixture of my zinc-sulphur paste with ichthyol, both regularly at the same time and with good result.

"But being slightly doubtful about the so-called internal reflex causation of this disease, I resolved three years ago to put aside all internal remedies, only relying upon my external treatment. The result was astonishing even to me. The cures were as rapid and radical as before, the children sleeping from the first night, the family too, and the outbreaks ceasing in the course of from two to three weeks. Of course this therapeutic success will never be a proof that an internal irritant in lichen urticatus does not exist. But I think it very probable that if there is an internal irritant one would see regular recurrences after a purely external treatment, which I, in fact, do not see.

"Of course, since that time I enquire more exactly than before about the possibility of external causes, especially insect bites, because the eruption appears regularly at night and chiefly on the covered parts. But I must confess that my investigations have been, up till now, fruitless. The central papule of the disease points to the probability that we have to deal with a yet unknown micro-organism, which has been implanted at these points by scratching—a mere working hypothesis.

"My treatment, in which I have absolute confidence, consists in the following points:—

"(1) Cover the child in the night with woollen Jaeger combinations. These alone represent the nightshirt, no linen being worn under or over it. During the day the child wears the same combinations with only a light woollen dress over them, so that day and night the skin is easily accessible and kept well anointed by the wool.

"(2) Regularly the child is anointed over the whole body three times in twenty-four hours with the following paste:—

Formula of my Zinc-Sulphur Paste.

Sulphur præcip.	10 per cent.
Zinci oxidi	14 „ „
Terra silicæ	4 „ „
Ol. benzoet.	12 „ „
Adep. benzoet.	60 „ „

To this add 5 per cent. ichthyol and 20 per cent. vaseline.

"Although the whole body is anointed at bedtime, the mother must watch every night attack and immediately itching begins apply more ointment to the scratched places. This becomes less frequent from night to night. The rarer instances of attacks during the daytime must be treated in the same way immediately.

"(3) During this whole treatment *every sort of bath is forbidden*, even washing with plain water is not allowed. The skin must always remain smeared. The underclothing is only to be changed when it becomes too greasy and therefore an irritant itself. This is usually necessary after three days. It is best to use two sets of combinations which are changed twice a week, the one set being washed while the other is worn. When after some weeks the skin has got a normal appearance, I begin to clean and wash it with diluted spirit and later on with soap and water.

"(4) There is no difference in this treatment, whether:—

"(*a*) The case has a history of days, weeks, months, or years.

"(*b*) The feeding consists in mother's milk, cow's milk, or other substitutes.

"(*c*) There are gastro-intestinal disturbances or not.

"(*d*) The constitution and nourishment of the child is a good or bad one.

"(*e*) The restlessness and irritability of the child is great or slight.

"(*f*) There is a secondary infection with impetigo or eczema germs, which are cured simultaneously by the same treatment, or not.

"In my opinion these experiences point to a specific organism being the cause of the disease, a specific remedy being *in fact in our hands*. It is in every case marvellous to notice how quickly from day to day changes towards recovery set in, *i.e.*, disappearance of the eruption, diminution of the itching and restlessness, and return to a good condition, not only of the child but also of the attending persons.

"In closing I must not forget to remark that in former times I ventured to make the reverse experiment, treating the cases internally alone, *without any external application whatever*. But I had very unsatisfactory results.

"Believe me, dear Mr. ——,

"Sincerely yours,

"P. G. Unna."

Our Lichen Scrofulosorum Portrait.

(Additional Particulars of the Case.)

It is to be expected that the general interest in the eruption known to dermatologists as Lichen scrofulosorum will much increase when its important relations to tuberculosis in internal viscera comes to be recognised. The portrait given as Plate CXLII. affords an excellent illustration of the mildest and most common form of this "miliary tuberculosis of the skin." Much more severe forms have been represented in Continental Atlases, more especially in that of Kaposi. To those accustomed only to the accredited British type of the malady some of these are with difficulty recognised as really representing the same disease. That they do so, however, and that consequently it is necessary that we should enlarge our conceptions of what may be properly included under that term, is undoubted. Some original portraits of cases of the severe type have recently been obtained at the Polyclinic, and will in due course be reproduced in this Atlas. In the meantime we desire to offer to our readers some additional particulars as to the case referred to, which bring the narrative up to date, and also more forcibly exhibit the relation of the eruption to visceral tuberculosis. In the description of the Plate it was stated that the boy's father had died of chest disease and that he himself had been sent to the seaside for a long residence on account of delicacy. We have since learnt that pulmonary phthisis was diagnosed at the age of 10 by a skilled physician, and that the boy subsequently resided in a sanatorium in Ventnor for two years. He was 7 years old when the portrait was taken and he is now 17. He has regained fair health and no longer shows any chest symptoms. He suffers, however, rather severely from Acne on the face and nape. He has for many years been quite free from the lichen patches on his trunk. No trace of them can be recognised.

Pigment Changes, Leucoderma, &c.

As supplementary to the statements and Plates contained in Fasciculus XXII. the following notes may be of interest:—

Piffard expresses the opinion that "in perhaps the majority of cases there is a return of the natural pigment after the lapse of a few years; while in others the affection appears to last a few months and disappears, only to be followed by one or several recurrences. I have met with several patients in whom the pigment was absent during the hot months and returned during the cold ones." It may be suggested that possibly all that occurs is that the browning of summer causes the white patches to become conspicuous by contrast.

He gives three photographs, all showing symmetry.

That the pigmentation of the skin is controlled rather by the supply of pigment by the blood than by any peculiarity in the organisation of the skin itself is a proposition which finds some support from experiment. It is supposed to have been satisfactorily established that if a portion of skin from a negro be engrafted upon a white person it will in time lose its colour, but if a portion of white skin be engrafted on a negro it will become black.

Persistency of Eruptions after leaving off the Drug which caused them.

In *Pathol. Soc.* for 1877, p. 247, Dr. David Lees recorded a case in which the spots continued to come out six weeks after the medicine was left off. The urine also during most of this time continued to show the reactions of bromine. Five grains of the bromide and three-quarters of a grain of the iodide had been given every three hours for a fortnight to a child under one year of age.

NOTICE TO MEMBERS.

At the conclusion of the year's issue for 1903, when three years of the Clinical Atlas had been completed, an Index was prepared for what will rank as the first volume of that work. During the two years which have since elapsed only six separate fasciculi have been issued, but owing to difficulties as to suitably dividing the plates, some of which had been printed and numbered beforehand, it has been found impracticable to allot them accurately. More than the promised number of plates for the two years have, however, been given. Having regard to this fact, and to the state of the Society's Funds, the Council has determined to conclude the issue for the closing year, 1905, with the present fasciculus, and to ask the Society's members to accept the above statement in explanation. This will enable the Council to commence the year 1906 promptly by the issue of a double fasciculus, now nearly ready, illustrating Variola, Varicella, and Vaccination. It will also much facilitate punctuality of issue in the future. The letterpress volume, which deals with the Parasite of Syphilis, that of Variola and other kindred topics, will also be counted as for 1906, instead of as originally contemplated for 1905.

It is proposed to present to all members who have joined during the year 1905 the two last fasciculi issued in 1904, so as to complete their total of four fasciculi for the year. Thus a matter of fairness to them, since the issue for 1904 was much larger than that for 1905.

It will be observed that the present fasciculus contains eighteen plates, and ranks as a double one.

AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY AND PATHOLOGY

CHIEFLY FROM ORIGINAL SOURCES.

FASCICULUS XXV.

SMALL-POX.

PLATES A TO F.—Discrete Small-Pox.

PLATE G.—Mild Small-Pox in the Unvaccinated.

PLATES H TO L.—Confluent Small-Pox.

,, M AND N.—Confluent Small-Pox (Variola Corymbosa).

,, O TO S.—Influence of Vaccination on Small-Pox.

PLATE T.—Chicken-Pox.

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DISCRETE SMALL-POX.

An average attack. (Plates A, B, C, D, E, are all from the same patient.)

The patient was a boy, aged 17 years, unvaccinated. Twelve days after contact with a person suffering from small-pox he was seized with headache, backache and vomiting, and his temperature rose to 104° F.

On the third morning his temperature was 99° F., and he appeared to be well, save for the presence of a few shotty papules on the forehead and arms.

On the fourth morning all the lesions had made their appearance on the trunk and limbs and were beginning to be vesicular.

PLATE	A.—	5th Morning.	General Distribution.
,,	B.—	9th ,,	,, ,,
,,	C.—11th	,,	Hands and Arms.
,,	D.—12th	,,	General Distribution.
,,	E.—16th	,,	Soles of Feet.
,,	F.—		Face.

NOTE.—The plates appearing in this fasciculus are, with one exception, prepared from photographs taken by Dr. Allan Warner, late Resident Medical Officer to the Isolation Hospital, Leicester. For the loan of the photographs and for the notes accompanying them the Society is indebted to Dr. Warner.

PLATE A.

DISCRETE SMALL-POX. Fifth morning.

Shews a number of vesicles on face and arms.

Bale and Danielsson, Ltd., London.

PLATE B (Same patient as Plate A).

DISCRETE SMALL-POX. Ninth morning.

(On the eighth morning the temperature was 102° F. Most of the lesions were fully pustular with bright areolæ encircling them).

Ninth morning.—Note the œdema of face. Some of the pustules have ruptured, forming dirty yellow scabs.

Bale and Danielsson, Ltd., London.

PLATE C (Same patient as Plates A and B).

DISCRETE SMALL-POX. Eleventh morning.

Shews the formation of the scab. Note that the pustules on the hands are in an earlier stage of development than those on the arm.

Bale and Danielsson, Ltd., London.

PLATE D (Same patient as Plates A, B and C).

DISCRETE SMALL-POX. **Twelfth morning.**

All the lesions are scabbed, with the exception of a few on hands and feet.

Bale and Danielsson, Ltd., London.

PLATE E (Same patient as Plates A, B, C and D).

DISCRETE SMALL-POX. Sixteenth morning.

Shows the appearance of the scabs on the soles of the feet.

NOTE.—This patient suffered from no complications, except for a slight attack of conjunctivitis. He returned home with slight staining of his face but no permanent pitting.

Bale and Danielsson, Ltd., London.

PLATE F.

DISCRETE SMALL-POX.

Shows typical scabs in a case of discrete small-pox. Note that some of the scabs have fallen off and have left small elevations on the skin. These are of darker colour than the rest of the skin and give rise to temporary staining.

Ulceration has taken place in some of the lesions, and will give rise to a cicatrix, which will contract and leave a more or less permanent white "pit."

Bale and Danielsson, Ltd., London.

PLATE G.

MILD SMALL-POX IN THE UNVACCINATED.

Mild attacks of small-pox occasionally occur in the unvaccinated, especially towards the end of an epidemic, the virus possibly being attenuated by passage through a number of resistant persons.

The boy (unvaccinated) illustrated in the plate was taken ill on May 30th. On the following day a single papule appeared below the left subscapular fossa, and he was admitted to the "Suspect" ward at the Small-pox Hospital.

On April 3rd, thirty-three definite papules appeared, distributed as shown in the plate (Eighth day, April 7th).

On April 10th all the lesions had scabbed, and a week later he was free from scabs. He had never been really ill during the whole of the attack.

Bale and Danielsson, Ltd., London.

CONFLUENT SMALL-POX.

PLATE H.—9th day. Pustular Eruption on Hands and Arms.

PLATES I to L.—A Series from the same Patient.

PLATE I.—3rd day. Face. Early Vesicular Stage.

,, J.—6th day. Face. Early Pustular Stage.

,, K.—10th day. General Distribution.

,, L.—13th day. Face.

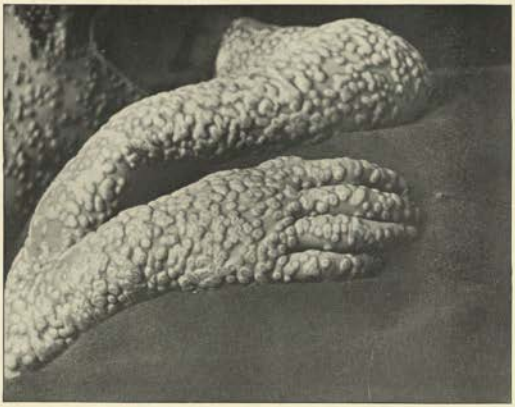
PLATE M.—17th day. Variola Corymbosa.

,, N.—10th day. ,, ,,

PLATE H.

CONFLUENT SMALL-POX. Ninth day.

From an unvaccinated girl, aged 11 years.
The plate shows confluent pustular eruption on hands and arms



Bale and Danielsson, Ltd., London.

PLATE I.

CONFLUENT SMALL POX. Third day.

Shows early vesicular stage.

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PLATE J (Same patient as Plate I).

CONFLUENT SMALL-POX. Sixth day.

Shows early pustular stage, which was accompanied by intense itching and discomfort.

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PLATE K (Same patient as Plates I and J).

CONFLUENT SMALL-POX. Tenth day.

The skin is deeply hyperæmic and the pustules stand out in strong relief from the dark background. At this time the patient was quite helpless and aphonic. Temperature 105° F. Pulse rapid, much fœtor, muscular tremor and diarrhœa.

Dale and Danielsson, Ltd., London.

PLATE L (Same patient as Plates I, J and K).

CONFLUENT SMALL-POX. Thirteenth day.

The photograph was taken one hour before death. The pustules have broken and a honey-like fluid has exuded, which has dried, rendering the skin stiff and covering it with mahogany coloured scabs.

Bale and Danielsson, Ltd., London.

PLATE M.

CONFLUENT SMALL-POX. Seventeenth day. (Variola Corymbosa.)

This is a rare form of small-pox, so called from the eruption assuming corymb-like masses. The prognosis in these cases is usually very grave.

Bale and Danielsson, Ltd., London.

PLATE N.

CONFLUENT SMALL-POX. Tenth day. (Variola Corymbosa.)

Note the hæmorrhage into the confluent pustules.

Bale and Danielsson, Ltd., London.

VARIOLOID OR SMALL-POX MODIFIED BY VACCINATION.

Plates O to S.

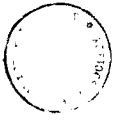

PLATE O.

VARIOLA AND VARIOLOID.

Shows two boys, both aged 13 years. The one on the right was vaccinated in infancy, the other was not vaccinated. They were both infected from the same source on the same day. Note that while the one on the left is in the fully pustular stage, the one on the right has had only one or two spots, which have aborted and have already scabbed.

Bale and Danielsson, Ltd., London.

PLATE P.

VARIOLA AND VARIOLOID.

Two sisters infected with small-pox on the same day from the same source.
Upper figure.—Girl aged 21 years, vaccinated in infancy.
Lower figure.—Girl aged 15 years, unvaccinated.

Bale and Danielsson, Ltd., London.

TO SHOW THE INFLUENCE OF VACCINATION DURING THE INCUBATION PERIOD OF SMALL-POX.

Plates Q, R and S.

PLATE Q.

CONCURRENT VACCINIA AND SMALL-POX.

Shows two girls suffering from small-pox with same date of onset. The one on the left had not been vaccinated. The one on the right had been vaccinated twelve days before the onset of the disease.

Note in the child on the right the scantiness of the lesions and also that they have completely scabbed.

Bale and Danielsson, Ltd., London.

PLATE R.

CONCURRENT VACCINIA AND SMALL-POX.

———

Vaccination nine days before onset of small-pox. Note that the protection is less than obtained in the case illustrated in Plate Q.

(Photograph from Dr. Hanna, of Liverpool).

Bale and Danielsson, Ltd., London.

PLATE S.

INFLUENCE OF VACCINATION DURING INCUBATION PERIOD.

To shew that the mildness of attack under these circumstances is not merely due to a natural family insusceptibility.

A boy, aged 14 years, unvaccinated, sickened with small-pox on April 14th. He was removed to hospital on April 18th, where he had a severe confluent attack. The father consented to his wife and three children being vaccinated, stating that personally he would not be vaccinated, but would be a "test," to see if there was anything in it. Ten days later his daughter, aged three years, developed a small-pox eruption; she had less than one hundred spots and never appeared ill. No other person in the house suffered from small-pox except the father, vaccinated in infancy, his eruption appearing fourteen days after the son had been removed to hospital. A photograph of the father and daughter, taken on the twelfth day of the father's eruption, may be seen in Plate VI. and requires no comment.

Bale and Danielsson, Ltd. London.

PLATE T.

CHICKEN-POX. (Varicella.)

This Plate is inserted to show the contrast between chicken-pox and small-pox.

The back and side of a child suffering from chicken-pox.

The following points are to be noted :—

1. Irregular distribution of the eruption.
2. Its polymorphism. This is due to the facts that many lesions abort in chicken-pox, and that they appear in successive crops.
3. Oval shape of many of the lesions.
4. Irregular crenate edge in many.

Bale and Danielsson, Ltd., London.

AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY

AND

PATHOLOGY

(CHIEFLY FROM ORIGINAL SOURCES).

FASCICULUS XXV. *bis.*

VARIOLA, VACCINIA, & VARICELLA.

PLATES 160–162.—VARIOLA.
PLATE A.—HÆMORRHAGIC SMALL-POX.
„ 163.—FATAL VACCINIA.
„ 164.—GANGRENOUS VACCINIA.
„ 165.—GANGRENOUS VACCINIA.
„ 166.—GANGRENOUS VACCINIA AND GANGRENOUS VARICELLA.
„ 167.—GANGRENOUS VARICELLA.
PLATES B TO G.—VARICELLA.

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THE NEW SYDENHAM SOCIETY.

VARIOLA.

PLATES 160 to 162.—VARIOLA IN DIFFERENT STAGES IN THE SAME PATIENT.

PLATE 160.—Fourth day of illness.

,, 161.—Eighth day of illness.

,, 162.—Tenth day of illness.

,, A.—Hæmorrhagic Small-pox.

PLATE CLX.

VARIOLA IN DIFFERENT STAGES IN THE SAME PATIENT.

FOURTH DAY OF ILLNESS.

Considerable difficulty is experienced in obtaining coloured illustrations of small-pox, owing to the natural reluctance of artists to incur risks of exposure.

The Society is indebted to Dr. Alexander McPhail, of Glasgow, for the three portraits now given, which illustrate the different stages of the eruption up to the tenth day. They are not given as illustrations of a typical case, but of what may occur in an exceptional one. Allowance must be made for the fact that the patient was a man of colour.

The first Plate shows the eruption as it was first recognized, and reveals the interesting feature that the spots, while few in number, were curiously grouped together.

The patient was one of a Lascar crew, and was observed by Dr. McPhail on board ship. He was thirty-five years of age. His illness began on September 18th, 1894, with headache, pains in back and limbs, sleeplessness, and vomiting. Quinine and phenacetin were given. On the 21st he drew attention to a few spots on his forehead. They were hard pimples, but as there was no general eruption they were not regarded as of importance.

On the 22nd shotty papules appeared over the whole body. The temperature had now reached 104·4.

On the 23rd "the eruption was still nondescript, some of the spots showing an advance towards breaking and scabbing, and others to surface blackening." The pulse had never been much quickened.

West, Newman, chromo.

PLATE CLXI.

VARIOLA ON THE EIGHTH DAY OF ILLNESS.
(Same patient as in Plate CLX.)

The eruption had now become general on the face, and was especially abundant on the cheeks.

The vesicles varied much in size, a few being as large as split peas. They were in many places confluent, and everywhere, where of appreciable size, showed depressed centres. They were present on the scalp and also on the hairy parts of the face.

West, Newman chromo.

PLATE CLXII.

VARIOLA; TENTH DAY OF ILLNESS.
(Same patient as in Plates CLX. & CLXI.)

The eruption has on some parts advanced to pustulation and ulceration. Some pustules are surmounted by crusts. There is a general œdema of the face, with partial closure of eyes from swelling of lids. The sides of the nose are severely affected, whilst the nose *tip* comparatively escapes.

On this, the tenth day of illness, the pulse was weak; there was noisy and incessant delirium, and great thirst. On the eleventh day considerable improvement occurred, the pulse became less rapid, delirium stopped, and the morning temperature was 99° F. Death occurred unexpectedly during the following night.

West, Newman chromo.

PLATE A.

HÆMORRHAGIC OR BLACK SMALL-POX. PURPURA VARIOLOSA.

The patient was an unvaccinated tramp, æt. 28 years.

On April 18th he complained of a feeling of weariness, with aching pains all over his body.

April 19th.—Temperature 105° F. The patient vomited almost continuously, and complained of very severe pains in back and epigastrium. He was covered with a universal deep brick-red erythema.

April 20th.—Fever maintained; the erythema was darker, and a few purple petechiæ appeared in the groins and on the back.

April 21st.—Admitted to small-pox hospital, with universal deep erythema, and studded with purple petechiæ. In addition there were numbers of larger violet spots. The conjunctivæ were blood-red from hæmorrhage. Hæmoptysis, hæmatemesis, and hæmaturia occurred. Death took place three hours after admission to hospital.

The photograph was taken on admission to hospital, and shows the petechial eruption in the groin and on the abdomen.

(From a photograph by Dr. Allan Warner, of Leicester.)

GANGRENOUS VACCINIA

AND

GANGRENOUS VARICELLA.

PLATES 163 to 167.

PLATE 163.—Fatal Vaccinia.

,, 164.—Gangrenous Vaccinia.

,, 165.—Gangrenous Vaccinia.

,, 166.—Gangrenous Vaccinia and Gangrenous Varicella.

,, 167.—Gangrenous Varicella.

PLATE CLXIII.

GANGRENOUS VACCINIA—FATAL.

The portraits given in this Plate were taken from the body of an infant aged about three months. Death followed vaccination. The particulars of the case were published by Mr. Jonathan Hutchinson in the 'Medico-Chirurgical Transactions' for 1881, and are as follows:—

A male infant, aged three months, and in excellent health, was vaccinated on November 11th, 1879, at a district office. The vaccination was from arm to arm, and the vaccinifer appeared to be in perfect health. Four others were vaccinated from the same source at the same time, and nothing unusual happened. On the eighth day after the vaccination the child was brought again to the station for examination. It had four pearly vesicles on the arm, which showed nothing unusual, but its body and limbs were covered by an eruption of a peculiar character. This eruption, which had been coming out for a day or two, was described by my informant, the vaccinator, as looking like small-pox. He said that the papules were distinctly shotty, and, believing it to be a case in which variola had been contracted prior to vaccination, he instructed the mother to take the child home and on no account to bring it to the station again. Four days later he visited the child at its home and found the pustules much developed, whilst in many of them gangrene was commencing. He now advised that the attendance of the parish medical officer should be obtained. This was not done, and between this date and that of the child's death no medical man saw it. The death occurred on November 30th, twenty days after vaccination. Under the peculiar circumstances an inquest became necessary, and an opinion having been expressed that the case was one of vaccinal syphilis, I was requested by the coroner to examine the body and make a report.

The state of the child's skin after death may be realised with tolerable accuracy by the portrait. The vaccination spots were covered with scabs, and there was a certain amount of congestion around them, but none of them were in the least indurated.

On the scalp and face there were spots and patches ranging in size from a shot to a shilling, some of them simply congested or scabbed, but others showing a central area of gangrenous skin. On the trunk, both back and front, there were similar spots with some much larger. All the larger ones showed a rim of deep ulceration which surrounded a central slough of black skin. From a few the slough had separated, a deep ulcer remaining. But few of the ulcers were quite round, and in many instances the shape was irregular, as if several spots had coalesced. The eruption occurred on both sides of the body alike, but as regards the larger eschars it was by no means arranged in exact symmetry. The back was very severely affected, and the lower part of the abdomen and upper parts of the thighs. There were some large eschars near the knees, but the lower halves of the legs and the feet, and the whole of both upper extremities below the elbows, were almost wholly free.

A post-mortem examination of the body was made, and the viscera were found free from disease, and the child appeared to have been in a state of good nutrition.

A case precisely similar to this will be found given, in detail, in the 'Archives of Surgery,' vol. iv. page 161. In that instance the body of the child was produced for demonstration at clinical meeting. It was covered with an eruption which it was impossible to distinguish from Variola, and many of those present declined to believe that it was other than that malady.

The history was, however, that the child had been in excellent health until vaccinated. When inspected on the eighth day after vaccination, the pocks appeared to be perfect. There was no undue inflammation or fever. A few days later, however, the infant appeared ill, and was taken to a surgeon. An eruption then appeared, which was suspected to be small-pox. As none of the spots were, however, definitely indurated, this suspicion was rejected.

The infant was not thought to be seriously ill until some days later still, when, the temperature having risen, and a fresh crop of spots having appeared, the suspicion

of small-pox was again entertained. Death occurred on the nineteenth day after vaccination (on the tenth of the febrile illness).

The two appended schedules will show how closely these two cases corresponded. It may be added that in neither instance did any facts occur in the family or neighbourhood to support any suspicion of contagion from either variola or varicella. In both cases the vaccination was from arm to arm, and in both, other children had been vaccinated from the same lymph without any ill results.

The cases are invaluable as implying the essential identity of vaccina with variola, and proving that the former is attended with definite blood changes and liability to pustular dermatitis. The cases may be compared with Plates CLXIV. and CLXV. and with fig. 1 in Plate CLXVI., in neither of which, however, did death result.

Death from Varioloid Vaccinia on the twentieth day.

An infant, male, æt. 3 months.

Day of Vaccination.	Date.	Details.
	Nov.	
1	11	Vaccinated from arm to arm.
2	12	
3	13	
4	14	
5	15	
6	16	
7	17	An eruption observed by the mother.
8	18	Inspected. Four good vesicles; an eruption in early stage.
9	19	The eruption was "shotty," and was supposed to be variola.
10	20	Eruption increasing.
11	21	
12	22	Some of the pustules had become gangrenous.
13	23	
14	24	Not seen by any medical man. The
15	25	body and limbs covered by an eruption,
16	26	of which many of the spots looked like
17	27	variola, and became crusted, but many
18	28	others passed into gangrene.
19	29	
20	30	The infant died.

Death from Varioloid Vaccinia on the nineteenth day.

An infant, male, æt. 8 months.

Day of Vaccination.	Date.	Details.
	Nov.	
1	27	Vaccinated from arm to arm.
2	28	
3	29	
4	30	
	Dec.	
5	1	
6	2	
7	3	
8	4	Inspected. All well, five good pocks.
9	5	Began to be feverish.
10	6	Eruption observed on the arm and on the face.
11	7	Eruption increased and becoming general.
12	8	A surgeon consulted.
13	9	Doubt felt as to whether it was small-pox.
14	10	Taken to St. Mary's Hospital.
15	11	Worse. Diarrhœa.
16	12	Seen by Dr. Chilcott. Temperature 103.
17	13	Temperature rather lower. A fresh crop of eruption. Renewed doubt as to small-pox.
18	14	Very ill. Temperature 104·5.
19	15	The child died early in the morning.

West, Newman chromo.

PLATE CLXIV.

VACCINIA WITH EXTENSIVE SUPERFICIAL GANGRENE.

This portrait is copied from one which was given to Mr. Hutchinson by the late Sir William Stokes, of Dublin. The patient was under observation in the Richmond Hospital in that city.

The case is published in Mr. Hutchinson's paper in the 'Medico-Chirurgical Transactions,' 1881, page 4. The Plate shows the sores which remained from three vaccination punctures on the left arm of a healthy child, and near to them are several irregular areas of gangrenous skin. On the child's face there are a number of pustules showing no very special characters, but some of them confluent and crusted. It will be seen that the vaccination sores themselves are not gangrenous, but are covered with grey lymph, and show no tendency to heal. There is a local patch of erythema immediately beneath the group which has not advanced to gangrene. The child was feverish and ill for some time, and large superficial sores resulted from the gangrene, which took several weeks to heal. Eventually, however, recovery took place. The details of the case were published by Sir William Stokes in the 'Dublin Journal for Medical Sciences' in June, 1880. The following statements are taken from that paper:—

The patient was a child of nine months old, and was in good health when vaccinated. She was admitted to the Richmond Surgical Hospital in the state shown in the portraits on February 17th, 1880. It was stated by the child's mother that vaccination was performed on February 7th, but this was disproved by the surgeon who was stated to have performed it, and no reliance could be placed upon the assigned dates. Not improbably the mother, anxious to connect the result with the vaccination, understated the interval which elapsed between the latter and the first appearance of the eruption. The condition when first seen by a medical man was described by Dr. Coppinger, of the Mater Misericordiæ Hospital, as follows:—"The child was covered with a petechial eruption of a purple black colour. There were large bullæ over the buttocks. The conjunctivæ were injected and the eyelids swollen. The vaccination marks were clearly seen on the arm." When some days later the child came under Sir William Stokes's care, "the body and face were sparsely covered with spots, each of these covered with a yellow scale, and exactly resembling the crust to be seen in a mild case of variola in the convalescing stage. There were large sloughing surfaces on both buttocks, on the back of the right thigh, on the calf of one leg, and on both arms."

The child had a troublesome convalescence and a week after admission she suffered from diarrhœa, and was so much reduced that it was feared she would die. Eventually, however, the sores healed and she regained her health.

West, Newman chromo.

PLATE CLXV.

VACCINIA ATTENDED BY GANGRENE.

This portrait illustrates the condition of the lower extremities in the same patient as the subject of the preceding Plate. Large patches of skin are seen to be in process of detachment after gangrene. They are very irregular in shape and nowhere deep, suggesting a comparison with thin kid leather. The surfaces adjacent to the gangrenous patches are granulating in a healthy manner. As stated in the description of the previous Plate, the child recovered well.

West, Newman chromo.

PLATE CLXVI.

GANGRENOUS VACCINIA AND GANGRENOUS VARICELLA.

The lower figure in this Plate is taken from a portrait which was done under difficulties, and must be regarded only as a rough sketch. The child was a Norwegian immigrant, who was vaccinated on board ship before being allowed to land in the United States.

The vaccination was from points, but probably from human lymph. The precise dates cannot be given, but were probably much the same as those in the preceding cases. The vaccination sore itself became the site of a small patch of gangrene. Only a few of the spots were attended by sloughing, and that only to a very limited extent. The eruption is seen to be fairly symmetrical on the two sides, and to occur freely on the limbs and face, but less so on the trunk. The child recovered with numerous small but rather deep scars.

The upper figure in this Plate is copied from a portrait taken at the North Eastern Hospital for Children, from a child under the care of Dr. Sansom and Mr. Waren Tay.

There were other cases of varicella in the family, but they were not attended by any unusual developments.

In this child, in the first instance, the eruption looked like ordinary varicella, and Dr. Sansom throughout made no doubt as to the diagnosis. Only a few of the spots became gangrenous. The portrait is given as a careful study of the local conditions presented by these. It will be seen that a small portion of skin, in one instance about as large as a four-penny-bit, and in the other as a split-pea, passed into gangrene. In the larger of these spots it is probable that the whole thickness of the skin was involved. The eschar has contracted, and a deep furrow is left, the margin of which is swollen and reddened. A deep scar would no doubt result.

West, Newman chromo.

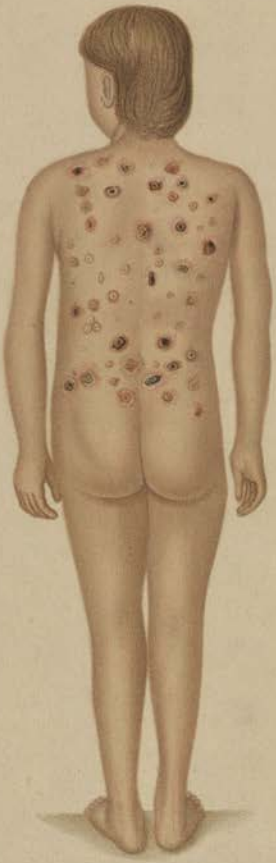
PLATE CLXVII.

VARICELLA GANGRENOSA.

This portrait is given in order to illustrate the distribution and conditions of a severe eruption of gangrenous varicella. It will be seen that it affects the face most severely and next the trunk, the extremities being almost exempt.

The patient was a child aged two years and a half, who was under observation in February, 1880. It will be noticed that on many of the varicella spots a portion of skin has sloughed and become black; in others the condition is one rather of necrotic ulceration than actual gangrene. She afterwards made a good recovery.

See 'Medico-Chirurgical Transactions,' vol. lxv. page 1, for a full report of the case and of several similar ones.



West, Newman chromo.

VARICELLA.

PLATES B to G.

PLATE B.—General Distribution.

,, C.—The Eruption.

,, D.—Varicella in a patient desquamating from Scarlet Fever.

,, E and F.—The Eruption.

,, G.—Unusually Severe Lesions.

For these Plates the Society is much indebted to Dr. E. W. Goodall, of the Eastern Fever Hospital, Homerton. The photographs were taken by Mr. J. Neale.

PLATE B.

VARICELLA. SEVENTH DAY.

This photograph shows the usual distribution of the eruption. The hands and feet are almost entirely free from pocks. The trunk, face, and proximal portions of the limbs are chiefly affected. Scabs and vesicles occur side by side. Some of the pocks have been scratched, and a little hæmorrhage has taken place. The patient was a boy, æt. 4 years.

PLATE C.

VARICELLA. FOURTH DAY OF ERUPTION.

The Plate shows the typical vesicles of chicken-pox on the buttocks and thighs of a girl, æt. 4 years. The following points are to be noted:—the pocks are evidently superficial; there is no surrounding inflammation; their size varies: some are distinctly oval; they occur in clusters of two or three; they occur in successive crops, and with the vesicles a few ill-defined macules and papules are to be seen.

PLATE D.

VARICELLA AFTER SCARLET FEVER.

The Plate shows the back of a boy, æt. 8 years, who developed chicken-pox whilst desquamating after an attack of scarlet fever. The Plate shows the desquamation fairly clearly. The boy had a profuse chicken-pox eruption, especially on the back.

Note the presence of many flat, irregular-shaped, superficial scabs. A few recent vesicles and pustules are also to be seen. Two or three are distinctly crenate. Some spots are abortive. The eruption, in fact, is polymorphous.

PLATE E.

VARICELLA. FOURTH DAY.

The Plate shows the face of a girl, æt. 4 years, who, whilst convalescing from diphtheria, underwent a sharp attack of varicella, with, however, not a very profuse eruption. On the fourth, fifth, and sixth days the temperature rose to 105° F.; the pulse-rate was as high as 148, and respirations 40. No complications occurred.

On the face the eruption resembles that of a mild case of small-pox. Three or four pocks are confluent about the mouth. Some of the vesicles are already beginning to scab. A good many of the vesicles became pustules.

The eruption appeared on December 30th on the trunk, neck, and thighs, and on January 1st on the face. The photograph was taken on January 3rd.

PLATE F.

VARICELLA.

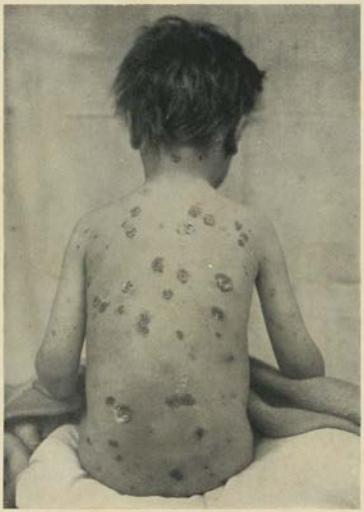
Right arm and neck of a boy, æt. 4 years. The vesicles were rather larger than is usual in chicken-pox, and some were distinctly crenate.

PLATE G.

VARICELLA. (Same patient as Plate F.)

The boy had had a mild attack of scarlet fever about a month earlier. The chicken-pox eruption appeared on November 22nd. The upper photograph was taken on November 27th. Several of the pocks are seen to have become inflamed, and are surrounded by large red areas. It was thought that they might become gangrenous, but they did not. Notice several small abortive pocks.

The lower photograph was taken on December 7th. Instead of becoming gangrenous, the inflammation subsided, and scabs quickly formed. These scabs were quite superficial, and ulceration took place beneath only two or three of them. On separating, the scabs left red staining of the skin, which subsequently disappeared. These severe lesions occurred only on the back. The boy was suffering from otitis media and slight mastoid inflammation (due to scarlet fever) when he was attacked by chicken-pox.



AN

ATLAS OF ILLUSTRATIONS

OF

CLINICAL MEDICINE, SURGERY

AND

PATHOLOGY

(CHIEFLY FROM ORIGINAL SOURCES).

FASCICULUS XXVI.

ECZEMA, LICHEN, AND TINEA. GOUT TOPHI. DARIER'S DERMATOSIS, &c.

LITERARY ROYAL ASIATIC SOCIETY

PLATE 167A.—ECZEMA OF HAND.
„ 168.—LICHEN AND LEUCODERMA.
„ 169.—TINEA OF ARM (CONTAGION FROM A HORSE).
„ 170.—TINEA OF FACE (CONTAGION FROM A HORSE).
„ 171.—GOUT TOPHI IN HANDS AND EARS.
„ 172.—CHRONIC DERMATITIS OF THE LIPS (FORDYCE'S MALADY).
„ 173.—LICHEN SCROFULOSORUM DIUTINUM (DARIER'S DERMATOSIS).
„ 174.— „ „ „ „

LONDON:
THE NEW SYDENHAM SOCIETY.

PLATE CLXVIIa.

ECZEMA OF THE HANDS IN A PAPER-STAINER.

The hand shown in this Plate is that of a lad of 14, who was employed in a paper-staining factory. His work required him to be frequently putting his hands into water, and often into water which contained chemicals. It was not possible to fix upon any one ingredient which caused irritation, but there was no doubt that the condition was due to his avocation. He was repeatedly allowed periods of rest, and always with immediate advantage. After much disappointment under very different forms of local treatment he was obliged finally to give up his employment.

The condition was one of diffuse eczematous dermatitis, with abrasions and fissures. There was no skin disease elsewhere.

It is of interest to note the manner in which the nails were affected. Inflammation, which began under the nail-fold at its root, led to erosion on the surface of the nail, and arrested its growth. The distal portion of the nail remained unaltered. The portrait may be considered a fair representation of the form of eczema of the hands due to occupation, such as occurs in sugar-bakers, brick-layers, &c.

West, Newman chromo.

PLATE CLXVIII.

A COMEDONOUS FORM OF LICHEN IN ASSOCIATION WITH LEUCODERMA.

The patient was a woman, aged 51, who had suffered from epilepsy, and had for some years been the subject of leucoderma in large areas on her limbs and neck. Her more interesting condition had, however, begun only a year ago. It consisted of grouped but ill-margined patches of lichen papules, which made the parts which they affected "as rough as a nutmeg-grater." Some of these spots showed little black comedones, and it was possible, with some difficulty, to squeeze out small sebaceous plugs The parts chiefly affected were the chest, the middle of the back, and the arms. The spots occurred freely on the regions made white by leucoderma; but were not confined to them. The face and backs of hands were free. The eruption had itched a good deal. In their earliest stage the spots were light pink in tint, and showed no conspicuous orifices. Many of the plugs were more or less acuminate, but none were actually spinous. The patient was thin, but not specially out of health.

The case seemed to belong to the ill-defined group of lichen cases which have received different names according to the predilection of the observer. Lichen scrofulosorum, lichen spinulosus, lichen acuminatus, and Devergie's lichen are some of those in use. That the pathological condition is induration of the structures about the orifices of hair follicles and the secretion of a firm sebum which cannot flow away is clear. Thus it is anatomically a comedonous lichen. Some approach to Darier's dermatosis may perhaps be claimed.

It is probable that the association with leucoderma was only a coincidence. A slight degree of congestion which occured around all the groups of lichen papules concealed to some extent the whiteness of the leucoderma. The papules appeared to be placed quite indifferently on the bleached areas and on those retaining pigment.

The grouping of the spots and their limitation to certain regions are features somewhat peculiar to this affection. In them it differs from what is illustrated in Plates 173 and 174, with which, however, it may be instructively compared. In some other similar cases this form of comedonous lichen has been observed in well-margined and strictly local patches. It is a rare affection.

West, Newman chromo.

PLATE CLXIX.

TINEA FROM CONTAGION FROM A HORSE.

This Plate illustrates the arms of a groom who had been attending to a horse with ring-worm. Large circular patches had formed, which showed, chiefly at their margins, numerous small pustules. The skin involved was congested and somewhat thickened, and there were present a certain number of minute comedones. There was a definite tendency to healing in the middle of the patches. The trichophyton was identified by the microscope.

In the next Plate the eruption is shown as it occurred on the man's face.

West, Newman chromo.

PLATE CLXX.

TINEA FROM CONTAGION FROM A HORSE.

This portrait is from the same patient as the preceding Plate. The eruption is seen to have destroyed the greater part of the moustache. On the upper lip and cheek it occurs in well-margined patches, but on the chin it is diffuse. On the cheek it has healed in the centre.

West, Newman chromo

PLATE CLXXI.

GOUT.

In this Plate we have a typical illustration of the conditions present in "chalkstone gout." The portraits were taken from an old man who was an inmate of a London workhouse, and who had suffered during the greater part of his life from attacks of gout, as also had his father before him.

On both ears are seen small tophi, the whiteness of which shows through the epidermis. They are arranged along the edge of the helix and the lower part of the antihelix. On the fingers are seen a number of other white nodules, thinly covered by epidermis. They are chiefly arranged over the terminal phalanges, but it will be seen that at other parts, notably on the index finger, there are fusiform bulgings, caused, no doubt, by the deposit of urate of soda in connection with the sheaths of the tendons or the fascia. The prominence of the knuckles, although deceptively like tophi, to which it often is due in such cases, was not really caused by them, but by the partial displacement forwards of the first phalanges. By this displacement the distal ends of the metacarpal bones were made to project. This explanation possibly does not apply to the prominence over the knuckle of the index finger, to which some tophaceous deposit had contributed.

The flexure of the fingers on the metacarpus, and the resulting contour of the hand, was probably attributable in large part to the use of a stick in walking. Attention may be drawn to the fact that the deposit of urate of soda in superficial parts appears to be somewhat acroteric in distribution, the ears and the terminal joints being the parts chiefly involved.

West, Newman chromo.

West, Newman chromo.

PLATE CLXXII.

SEBORRHŒIC DERMATITIS OF THE PROLABIUM. (FORDYCE'S MALADY.)

This Plate is copied from a portrait kindly supplied by Dr. Jamieson, of the Edinburgh Royal Infirmary, and the following is from his description of the case:—

B.S., Jew, male, æt. 33, native of Russian Poland. Occupation, tailor in rubber works. Admitted to the Infirmary in June, 1895. Pale complexion, healthy; no history of Syphilis. Father 80, mother 65, both well. Sisters all alive and well. Five children. Was a great smoker until the lip became affected, smoking principally cigarettes, and on right side. The disease made its appearance three years before admission, commencing on the left side as a scaly spot; this remained much the same for two years, then it extended, and the whole lip had been involved for seven months. Tongue clean; no enlargement of glands. Lower lip only affected, and in its entirety. Lip swollen to double its normal size, and everted. The surface bled readily. Extreme lower edge for about an eighth of an inch in the centre seems healthy, then there is a white cicatricial condition on each side of lip close to the commissure. The central portion is partly reddish and granular, partly covered with dirty yellow crusts, partly cicatrized, the cicatrix soft and white. The inner surface shows a whitish pellicle over the red mucosa, which gradually fades away. The gums, particularly the interdental folds, are swollen and fungating. The lower teeth are brown, and encrusted with tartar. At times pain of a darting character was experienced, or a sensation of burning. Drawing made on admission. Treatment: boric starch poultices, and cold cream ointment. This cleaned the lip. It was also cauterised with 50 per cent. lactic acid in water, and dressed with zinc ichthyol salve muslin, several times. In September he showed himself; for six weeks he had been applying collodion and pressure. The epidermis had grown over the surface, there were no crusts, and the lip was much less swollen and not painful. It was again swabbed with lactic acid.

In 1896 a small spot appeared on the left side of the nose. This was dry and slightly scaly. It extended, and by December, 1903, there was a dry, infiltrated, papillomatous area on the bridge of the nose, an inch vertically by an inch and a half transversely at its broadest part. This had an uneven warty surface, bearing in places hard, firmly adherent, splintery scales. The margins were sharply defined. The colour was a pale pink, and the skin was movable. The aspect was that of the warty fixed form of lupus erythematosus. The lip was dry, reddish in hue, swollen double its normal size, and protruding. The lower margin then showed a fringe of warty projections not unlike those on the nose, and the appearances were much what one would associate with lupus erythematosus affecting the lip. No treatment, including prolonged exposure to the light from the Marshall and Woods lamp playing on the part, did any good.

The affection, of which Dr. Jamieson's portrait gives an excellent illustration, is one which in lesser degrees is not very uncommon, and has claimed the attention of many observers.

It will be seen that it shows two somewhat distinct conditions. The row of yellow lines nearest the mucous membrane are the engorged racemose glands, and there is between this row and the anterior part of the prolabium a distinct interval. In front of this bar the conditions are those of congestion and peeling with encrustation. (It must be understood that the lip is intentionally everted.)

At page 131 of vol. ii. of 'Archives of Surgery' (1890), will be found the record of a series of five cases more or less similar. They were, with one exception, however, much less severe. In all, it had been long persistent. In one, a mother and daughter were affected. The difference in severity might probably be accounted for by the different amount of attention by the use of lip-salves, &c., which the lips had received. In the report referred to no mention was made of the state of the racemose glands of the lip, although it was suggested that the affection might be allied to seborrhœic eczema. Some years later, however, in the same Journal the following reference to these glands was made (see 'Archives' for April, 1896).

"RACEMOSE GLANDS IN THE PROLABIUM OF UPPER LIP.

"In the prolabium of the upper lip there sometimes appears a row of enlarged glands. They form a broadish streak along the middle of the prolabium, not touching the edge of either skin or mucous membranes. They are minutely racemose and like the meibomian glands. The following is an illustrative case:—

"Mr. W——, æt. 22, who shows this streak, has known of it for a year. They cause no soreness. There are none on the lower lip and none in the cheek pouch. The glands are of a yellowish-grey colour. They were sufficiently conspicuous to have attracted the patient's attention, and he asked me about them. When his mouth was shut they were scarcely to be seen.

"These glands may be found in the lips of many persons if carefully looked for. It is very seldom, however, that they become conspicuous. It is much more difficult to find them in the prolabium of the lower lip."

The affection was described by Dr. J. A. Fordyce in detail in 1896, and was illustrated by a good portrait. The following is his account of it:—

A PECULIAR AFFECTION OF THE MUCOUS MEMBRANE OF THE LIPS AND ORAL CAVITY.
By J. A. FORDYCE, M.D.

A physician consulted Dr. Fordyce in the autumn of 1895 for an affection of the mucous membrane of the lips and oral cavity. The patient's attention was first attracted to the condition about two years ago by a symmetrical fading of the vermilion border of the upper lip, extending from the corners of the mouth almost to the median line, leaving only a narrow margin free next the skin and a wedge-shaped area in the centre of the lip. The two patches were connected at the inferior median line, where the lips come in contact, by a segment of a circle, making three patches, all of uniform colour, with well-defined borders and areas slightly elevated. When first noticed the colour was but a shade lighter than normal; the appearance otherwise did not seem abnormal, but, by putting the tissue on the stretch, small, irregular, closely aggregated milium-like bodies of a light yellow colour just beneath the surface epithelium were plainly visible and completely covered the patches. While the borders appeared as well-defined lines, a chain of from one to three milium bodies could occasionally be seen in advance of the main patch, but not disconnected. The two sides have progressed symmetrically. On the lower lip was a parallel line of similar bodies extending horizontally through the centre. The patient is unable to state positively whether there has been any extension of the condition since it was first noticed; he is positive, however, that the colour has become lighter within the last six months. This, he thought, might be due to the fact that the bodies have become more closely aggregated. The subjective symptoms have been slight. The patient experiences at times a slight immobility of the upper lip, which he is inclined to attribute to dryness. This feeling preceded the onset of the above condition by several years. Within the past year he has felt a slight burning and itching of the upper lip, accompanied by some stiffness, as though the lip was swollen.

An examination of the mucous membrane of the mouth revealed a similar condition extending along the line of the closed teeth from the angle of the mouth backward to a point opposite the last molar teeth. The lesions in the mouth were lighter in colour, and in places somewhat elevated and papillomatous in character.

On the lips, the yellowish-white bodies imbedded in the mucous membrane suggested the ordinary milium seen on the face. An endeavour was made to remove them by incising the skin and picking them out with a needle. They were, however, found to be firmly adherent, and could with difficulty be detached from the surrounding tissue. When the superficial layer of the epithelium was scraped away, some of the bodies could be pressed out.

Microscopic examination revealed changes, chiefly confined to the epithelial cells, the protoplasm of the cells being apparently converted into a substance allied to kerato-hyalin, which under normal conditions does not exist in mucous membrane. Dr. Fordyce says that it is more than probable that some degenerative change of an unknown nature has taken place in the cell protoplasm, as indicated by the breaking up of the cell contents into irregular masses. The mucous glands were normal, their cells presenting no appearance like those in the epithelial covering. There was also no evidence of any inflammatory process in the sub-epithelial tissue.

This patient subsequently found the same condition in all the members of his family, from the youngest (seventeen) to the eldest (forty). He also found the condition to exist in a very large number of negroes. A good coloured Plate illustrating this case is to be found on page 412 of the 'Journal of Cutaneous Diseases, for November, 1896.

Under the conditions of chronic inflammation of the lips which may in the future go under the name of "Fordyce's malady," we must recognize the several pathological elements already alluded to. There is (*a*) peeling of the epithelium with encrustation, (*b*) engorgement of the racemose glands, (*c*) and more or less of papillary hypertrophy. All these were present in Dr. Jamieson's patient. The last-named, which in most is almost

wholly absent, was so definite, that the commencement of epitheliomatous growth was suspected. On part of the prolabium the condition is one of peeling and encrustation, and behind this the row of enlarged glands is clearly seen. This last condition may be overlooked unless specially searched for, and the same remark applies to the affection of glands in the cheek pouches which Dr. Fordyce refers to so prominently. This latter is very common in cases in which the lips are not affected, or but slightly so. The chronic cheilitis with which we are concerned is in slight forms exceedingly common, and only attracts attention in neglected and aggravated cases. It will not be of any clinical advantage to attempt to group these cases under new designations, having reference to single features which may preponderate, since it is obvious that they usually occur in combination. The conditions are sometimes observed chiefly on the lower lip and sometimes on the upper, more rarely on both. All observers are in agreement that they are very difficult of cure, although they may be much ameliorated by attentive treatment on general principles.

It may be suggested that a considerable part of Dr. Fordyce's description applied not to pathology but to anatomical conditions. He states definitely that the mucous glands were normal, but the racemose glands in question are sebaceous rather than mucous, and of them he takes no account. It is possible that the bodies described as "round" were some of them at least distended acini of the racemose glands. It is beyond doubt that the racemose glands of the prolabium are in some instances as definitely visible as are the meibomian glands of the eye-lids, which, indeed, they much resemble. From a notice of Fordyce's malady in Stelwagon's treatise on skin disease, we learn that Dr. Fordyce subsequently modified his opinion as to the nature of the bodies he described, and recognized their sebaceous character. A reference to the subject, with description of a case, will be found in a recent number of the 'Polyclinic Journal.'

To Dr. Fordyce belongs the credit of having given the first pictorial representation of this form of disease, and of having contributed some interesting facts; but his description was by no means the earliest. The paper already mentioned in vol. ii. of 'Archives of Surgery' was published in 1890, and in the same year Unna published two cases, and even proposed for them the designation of "Erksanking der Lippen Schleimdrüsen," or Baelz's malady, Baelz being the name of a coadjutor who brought the first case under his notice.

In 1893, Dr. Purdon, of Belfast, described four cases, and in 1895, Dr. Galloway brought a case before the Dermatological Society of London.

So far back as 1871, Volkmann, of Halle, described cases of inflamed lips under the diagnosis of *Cheilitis glandularis apostematosus*. In spite, however, of his association of the disease with glands, it is quite clear that he wrote of a quite different malady to that with which we are now dealing. His final adjective, indeed, sufficiently proves that the glands he refers to were the mucous glands, and his patients were most of them the subjects of syphilis, with the swollen, suppurating, and everted lips which are not infrequently seen in that malady. The orifices of the glands, were he says, large enough to admit a small probe. In the malady illustrated in our Plate and described in the papers we have quoted, the muciparous glands are seldom if ever affected, and suppurative inflammation is absent. The best descriptive designation for it would probably be SEBORRHŒIC DERMATITIS OF THE PROLABIUM. It is remarkable that the existence of the racemose glands appears to have been overlooked by most observers, anatomists as well as dermatologists. It may be plausibly suggested that the starting-point of the affection is defective secretion by these glands with inspissation, of what ought to constitute a natural lip-salve.

(J. HUTCHINSON.)

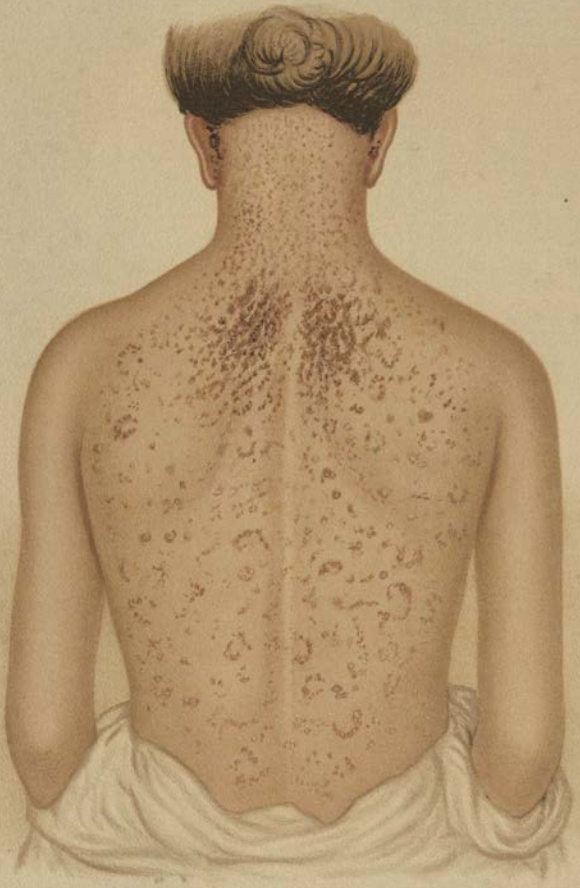
PLATE CLXXIII.

DARIER'S DERMATOSIS.

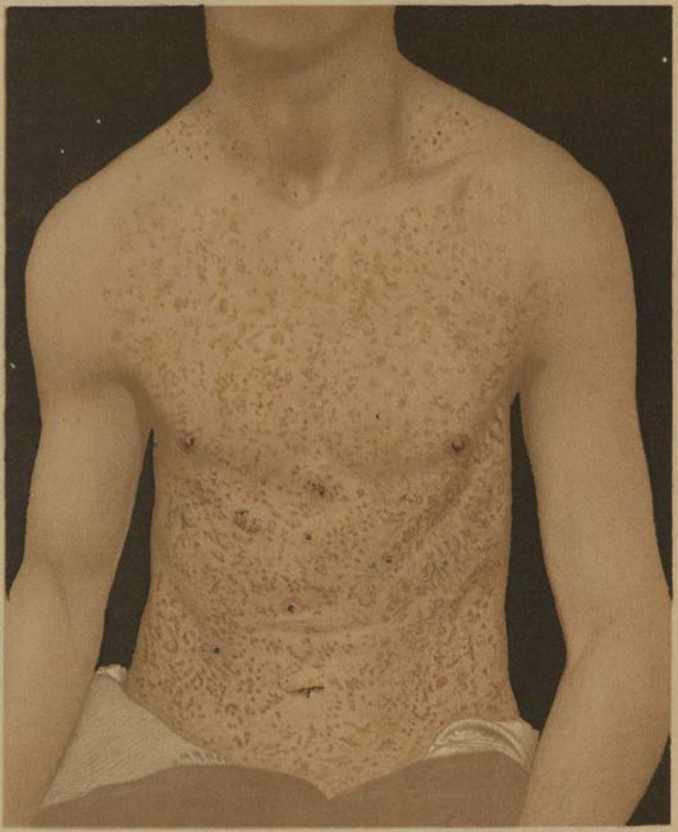
The patient whose condition is represented in this Plate was an intelligent girl of fair skin and well-formed features. She was fifteen years of age, and had suffered from the skin disease which is here depicted for nearly eight years. She was one of a family of nine, and she stated that all her brothers and sisters were delicate, and that two had habitual coughs. Her mother also was delicate. There was, however, no proof of definite tuberculosis in any. She had been under treatment in several London hospitals on account of the state of her skin, and her case had excited considerable interest. She was brought to the Polyclinic by Dr. Hartigan, from the Blackfriars Hospital for Skin Diseases. Dr. Hartigan had previously taken her, as well as the patient in the following case, to a meeting of the Dermatological Society of Great Britain and Ireland.

The conditions present may be described as follows:—

Large portions of the surface were covered by an eruption, which rendered it rough and almost spinous to the touch. The eruption consisted of dusky papules, many of which were discrete, whilst some were arranged in crescents. There were no circles and no abruptly margined patches. The eruption was especially abundant on the back and shoulders, but it covered also the whole of the front of the trunk. It was arranged with bilateral symmetry. It was not quite the same in all parts. Behind the ears on both sides there were groups of small comedones. On the upper part of the forehead and extending amongst the roots of the hair the eruption assumed the form of seborrhœic eczema, and this extended somewhat upon the hairy scalp. On these parts the lichenoid condition was wholly concealed.



West, Newman chromo.



West, Newman chromo.

PLATE CLXXIV.

DARIER'S DERMATOSIS. (LICHEN SCROFULOSORUM DIUTINUM.)

The subject of this case was a young man of 24, who, as well as the preceding patient, was brought by Dr. Hartigan to Mr. Hutchinson's post-graduate clinique. Dr. Hartigan brought also some microscopic specimens, which well demonstrated the ovoid refractive bodies formerly considered to be coccidia. The man had been a sailor. He was of a pale, pasty complexion. He had suffered from his skin disease for five or six years, and stated that it had commenced on his forehead, and had gradually increased in severity. It had not caused him much trouble, nor had it in any way interfered with his health.

On the sides of his temples and on some parts of his face the eruption was not distinguishable from an indolent non-suppurative form of acne. On the neck and the whole of the trunk the eruption everywhere consisted of lichen papules in various stages. Many of these showed minute comedonous plugs. They caused the skin to be very rough (like a nutmeg-grater), but no actual spines could be demonstrated. The eruption did not itch. There were present behind the ears groups of comedones exactly such as are described in the accompanying case.

GENERAL STATEMENTS.

Attention may be especially directed to the following points in which these two cases correspond. The eruption was very chronic and indolent. It evidently implicated chiefly the sebaceous system, assuming on different parts the conditions of seborrhœic eczema, comedonous acne and lichen. It was not attended by any material itching, nor by any inflammatory congestion of the skin. It prevailed chiefly on the parts protected by the clothing, and assumed its most definite lichenoid symptoms on these almost exclusively. It had resisted during many years all methods of treatment. Whilst there was no history of definite tuberculosis in either case, in neither could the patient be considered robust, whilst in one there was decided delicacy.

In discussing the question as to whether these cases should be allotted to a new group under the designation of Darier's Dermatosis, or be assigned to lichen scrofulosorum (accepting that term in a liberal sense), we have to remember that they are extreme examples of what in minor degrees is not uncommon, and that they connect themselves in various features with other well-known and named maladies. Cases precisely similar to them, and having attained a like development, are very infrequent, but this may easily result from the fact that most such submit to treatment at an early stage. It is generally admitted that cases which in England are diagnosed as lichen scrofulosorum are easily curable, or even possibly prone to disappear spontaneously. On the Continent the term lichen scrofulosorum is used in a much wider sense than with us, and, whilst the majority of cases are curable, a certain number are admitted to be intractable, and to attain degrees of severity far beyond anything which is recognized under this name in England. In illustration of this it is only needful to refer to the numerous portraits published in Kaposi's 'Hand-Atlas.' There can be little doubt that the two cases upon which Darier based his opinion and description, and to which he gave the name of "psorospermose folliculaire végétante," were counterparts of the two which are here published.

His supposed recognition of psorosperms is, however, now recognized as an error. The bodies so named are not parasitic, but result from vacuolation, and are indicative of very chronic degenerative changes. Here we are on firm ground, and, whilst placing Darier's cases and the present ones as belonging unquestionably to the same group, we may deny that there is any evidence whatever of their parasitic origin or specific character. If, then, they be relegated to the large and ill-defined family to which the term lichen has been applied, we have next to ask how they compare with the cases published by authors as belonging to that category.

In addition to the term lichen scrofulosorum which Hebra applied to cases of indolent lichen occurring in scrofulous subjects, we have several others. Thus the term lichen spinulosus has been applied to cases in which a small spine-like projection is produced in connection with the pilo-sebaceous follicles. These spines are epidermic rather than sebaceous, but they occur in association with minute comedones, of which they

are, after all, very probably a modification. It may depend upon the peculiarities of the patient's skin and the degree of activity of the sebaceous glands themselves whether a comedo or a spine be the result. Devergie's lichen is a term often used, but seldom or never defined, and is perhaps usually applied to local conditions in which the backs of the hands are chiefly affected. It is not known that Devergie ever described a spinulosus form of lichen, and it is difficult to distinguish cases to which his name is now given from local manifestations of lichen scrofulosorum. Very similar remarks apply to what is sometimes termed lichen pilaris, if we put aside certain peculiar conditions in which an imprisoned hair is coiled up in an obstructed follicle. We must leave aside, also, certain forms of lichen obviously due to external irritation—tar, for instance. Restricting our purview to cases of a chronic lichenoid condition occurring chiefly in young people, affecting chiefly the parts which are in contact with clothes, free for the most part from itching, we have to ask whether they can be divided with any definiteness into more than one group, and whether any group can be constructed which does not connect itself in more or less close identity with what we ought to name lichen scrofulosorum. The following citations from authors may perhaps help us to answer this question.

It will be well to remember, with reference to what has been suggested as regards the influence of clothing, that the kind of irritation caused differs very much in different individuals and in relation to the clothing worn. Probably in almost all persons woollen clothing, especially if worn at night, tends to stimulate the action of the sebaceous glands, and, in those who are inattentive as regards frequent changes, chronic forms of lichen are apt to occur. If, the patient inherit tuberculous tendencies and the bacillus be present it may be plausibly suggested that the lichen will assume the scrofulosus type. The entire absence of Darier's Dermatosis amongst the richer classes of the community has probably an important lesson in this direction.

Hebra's original description of the eruption which he named "Lichen scrofulosorum" will be found in the second volume of the New Sydenham Society's translation. The translation was by Dr. Hilton Fagge, who, in a footnote stating that the disease had not been recognized in England, suggests that some of the cases which Hebra himself had shown him in Vienna might have been named in England lichen circumscriptus. Hebra described groups of indolent papules which did not itch much, and which occurred chiefly on the trunk. They never suppurated, and were but little scratched, but in late stages they resembled acne spots, which might occur on the face and limbs, and went through the same stages as acne. When the little papules disappeared, discoid darkly pigmented maculæ, the size of lentils, were left, and the skin generally assumed a peculiar cachectic appearance. The disease might go on in successive crops for many years. Very usually other indications of scrofula in glands, bones, &c., were present, but not tuberculosis of the lungs. The papules were seated at the openings of hair sacs, and usually formed elevations which consisted of a mass of epidermis. After removal of these semiglobular masses of epidermis, the orifice of the hair sac might be easily seen. The surrounding skin was slightly reddened. It was a disease met with in males only, and Hebra especially admitted that some of his patients had appeared to be in excellent health. He thought the disease readily curable by efficient treatment, but showing no tendency to spontaneous disappearance. His remedy was cod liver oil internally and externally. By far the most important measure was rubbing in the oil four times a day and clothing the patient in flannel saturated with it. Of this he speaks as an infallible cure.

Hebra, in his large atlas, gave one portrait of the eruption. It was that of a man, and exhibits conditions which might very well pass for those of Darier's malady. The eruption is shown on the arm quite as abundantly as on the trunk.

In the 'Hand-Atlas' subsequently published by Kaposi (Hebra's son-in-law) the original portrait is reproduced and several new ones added. Unfortunately, no letterpress descriptions accompany this work. One of the portraits is named "*Lichen scrofulosorum et. acne cachecticorum*," and shows the eruption on both trunk and upper extremity. In another, Tafel, 178, the eruption is very abundant and severe. The conditions represented are precisely those of Darier's disease, and the localities affected are also similar. Groups of papules are shown in the fossa between nose and cheek, just as noted repeatedly by those who have described this latter malady. The arms are affected quite as severely as the trunk. No one who has seen examples of Darier's malady, and who carefully inspects this portrait, can doubt the identity of the two. A further portrait, Tafel, 179, is named "*lichen scrophulosorum et chloasma cachecticorum*," and shows the eruption on the trunk and limbs, and even on the backs of the hands. It occurs on the forehead and cheeks, and is again not distinguishable from Darier's malady. Tafel, 180, is named "*lichen scrofulosorum serpiginosus*," and exhibits large circumscribed dusky patches, with spreading lichenoid borders, on the trunk of a young man.

The last of Kaposi's portraits, Tafel, 181, is named "*lichen scrophulosorum et acne cachecticorum et eczema*

cum schorrhœa genitalium." This portrait, in the severity with which the genitals are affected, might almost be paired with Darier's own portrait. Numerous small scars are shown on the trunk.

This last-named portrait is the last of the series given under the diagnosis of lichen scrofulosorum, but there is yet another under that of "*Psorospermosis—Darier*," Tafel, 285, of yet greater interest. It shows the back and the back of one hand of a young subject, and both are covered by a disseminate lichen eruption. The hand might serve as a type illustrative of what in England is usually called Devergie's lichen, and the trunk for what is called lichen scrofulosorum. Thus what Kaposi names lichen scrofulosorum is what we in London should call Darier's psorospermosis, if we need use such a name, and what he calls psorospermosis is what we should call lichen pilaris or scrofulosorum. No better illustration could be offered of the almost hopeless confusion of meaning with which these names are used.

Radcliffe Crocker's Plate XXXIV., with its descriptive letterpress, is of great clinical value. The conditions delineated are from two different subjects, and the nominal diagnosis is that of "*lichen pilaris*" seu "*spinulosus*" in the one, and "lichen scrofulosus" in the other. It is stated definitely that lichen pilaris must not be confused with keratosis pilaris, but the only difference alleged is that the one is absolutely without congestion. If the term keratosis pilaris be restricted to cases probably of congenital origin, and true ichthyotic relationship, then an essential difference from lichen pilaris may be admitted; otherwise it will become very difficult to establish one. The Plate illustrating Crocker's case shows exceedingly well the spiny projections, better perhaps than any other published Plate. The spines are, however, not very numerous, and they are scattered over a surface which displays the more ordinary conditions of lichen scrofulosorum (compare with Hebra's Plate). The patient was a lad of 15, thin, pale and delicate looking, but without definite evidences of scrofula. The duration of the disease is not stated.

The figure which illustrates "*lichen scrofulosus*" shows the leg of a boy of 6. The lichen papules cover the whole front of the leg, and extend on the toes almost to the roots of the nails. The notes state that it was abundant also on the trunk, but less so on the upper extremities. It had been present two months, and the boy had also enlarged glands of the neck. This Plate should be compared with Kaposi's "psorospermosis," adverted to above.

In Plate LXXXVII. of Crocker's magnificent atlas just referred to we have a portrait of "*follicular fibroma of the back.*"

It is difficult to see any good grounds either in the portrait or the narrative for detaching this case from lichen scrofulosorum. The patient was the subject of adenoma sebaceum, and at the same time of a chronic lichenoid eruption on the trunk. The latter is thus described: "groups of hair follicles on the back having around them fibrous thickening forming hempseed-sized papules, or when closely aggregated forming a flat and fibrous-looking patch generally dotted over with large comedones." . . . There were also some large comedones and papules situated at the hair follicles, neoplastic, but not inflammatory, of the same colour as the normal skin and ranging from a pin's head to a hempseed in size. The portrait shows these both scattered and in a large group. The patient was a girl of twenty, and the eruption on the face and trunk was stated to have begun at the age of 14.

It is said that the microscope showed "the lesions on the back to be fibromatous growths round hair follicles."

Jacobi, in his portfolio of Dermochromes, devotes fig. 28 of Plate XVI. to "Lichen scrofulosorum," and gives as an alternative designation "tuberculosis milio-papulosa aggregatio." He says that the papules are but rarely transformed into pustules, and states, "the disease is undoubtedly of tuberculous nature, as shown by reaction to tuberculin, the anatomical structure of the miliary tubercles, and the discovery of bacilli in them." He suggests that they are "caused by bacilli of slight virulence."

This author appears to limit the term lichen pilaris solely to cases in which an imprisoned coiled-up hair can be detected. He alludes, however, also to small horny plugs, and says that the disease is met with chiefly in children, and is very difficult of cure. There is nothing in his description or portrait which is not applicable to lichen scrofulosorum. The same remark applies, with emphasis, to his description of "*pityriasis rubra pilaris*," the diagnosis of which is made, he tells us, without difficulty, "by the presence of the *white* horny masses and their localization." The localization given is precisely that of Devergie's lichen (or lichen scrofulosorum), and it is expressly stated that the papules form round follicles, and are often crateriform and penetrated by hairs. It is added that they are of a white or greyish tint, and make the skin rough like a nutmeg-grater. Surely, for such an eruption, the name "pityriasis" and the adjective "rubra" might both well be omitted?

In the excellent treatise on dermatology by MM. Hallopeau and Leredde (1900) we have a chapter on *kératose pilaire*, under which name is included xérodermie pilaire, ichtyose folliculaire, ichtyose ausérine, folliculite rouge, lichen pilaire. Lichen scrofulosorum is treated of in a different chapter and is defined by Hallopeau, "Toxi-tuberculides papulenses miliaires des glandes sébacées."

He inclines to attribute the eruption, not so much to the presence of bacilli in the skin itself, as to toxin supplied from other centres of disease and exercising an irritating influence on the cutaneous glands.

He appears to consider the presence of other scrofulous lesions as a very important aid in the differential diagnosis.

In January of 1901 Dr. Pringle brought before the Dermatological Society a boy, aged 13, in whose case he had made the diagnosis of an "eruptive tuberculide or lichen scrofulosorum of unusual character."

The eruption was very extensive, covering the face, neck, trunk, arms, and upper parts of thighs. The face was thickly studded with pale grey miliary papules, some already in the stage of branny desquamation, whilst the skin of the chest and trunk was acutely congested, dry, and harsh to the touch, and covered with closely packed small acuminate papules. The eruption had been observed only ten days, and its development had been attended by slight temperature—99·4°. The boy was pale and flabby, and had enlarged glands in the neck, but he asserted that he felt quite well and had a good appetite. There was no itching nor other subjective symptoms. The peculiar features in this case are its acute character and rapid development, but on the latter head some margin must probably be allowed for inaccuracy of the patient's observation.

At a meeting of the Dermatological Society of Great Britain and Ireland in June, 1901, Dr. Graham Little brought forward a case of "multiple lupus vulgaris of the psoriasiform type, showing also lichen scrofulosorum on both legs."

In vol. xi. of 1899, at p. 38, we find the report of a case exhibited by Dr. Radcliffe Crocker, in which a young child was the subject of lichen scrofulosorum in an extreme degree, together with a certain amount of lichen pilaris—little horny pegs in the orifices of the papules. Dr. Crocker remarked that lichen pilaris, by which he apparently designates an eruption attended by these little horny pegs, might occur as a complication of lichen scrofulosorum, and adds a statement of much interest from one of his wide experience that extreme cases of lichen scrofulosorum are somewhat rare. It would be of great interest to know what conditions he has recognized as extreme cases. There was some evidence of tubercle in his patient, but none of the more ordinary conditions of scrofula. Near relatives had suffered from phthisis.

A very characteristic example of lichen scrofulosorum was described by Dr. Caspar Gilchrist in one of the 'Johns Hopkins Bulletins,' May, 1899. His patient was a negro girl, who was healthy and well nourished, and in whose family there were but the slightest traces of tuberculosis. Nearly sixty groups of the characteristic lesions were scattered over the body. The case is of much value on account of the care with which the microscopic examination was carried out. In a few sections the arrangement of the exudation surrounding giant cells was very suggestive of tuberculous structure, but no tubercle bacilli were found. He drew attention to the reports of successful infection of susceptible animals from cases of the disease by Jacobi, Haushalter, and Pellizarri, and evidently leant towards the opinion that the disease was of a truly tuberculous character.

From a report in the 'Journal of Dermatology' for 1896, p. 326, we learn that "Dr. Edward Mackey showed a very beautiful photograph of a case of lichen pilaris (spinulosus) affecting the nape of the neck of a girl, aged 12. It had been somewhat neglected, and had existed for two years when she came under observation. Similar patches were present along the edges of the axilla and over the bam muscles. The affection had yielded to treatment in the hospital by the use of frequent baths, and the application of alkaline lotions and tar."

The journal from which we have quoted the preceding cases offers us a mine of facts in reference to the maladies in question. At page 152 of vol. vii. is a report of three cases exhibited by Dr. Colcott Fox. One of these ranked as an example of lichen spinulosus of Devergie or lichen pilaris of Crocker. The patient was a delicate boy, aged 7, who had suffered from a bad throat and swollen neck glands. The eruption was arranged in patches on the forehead, limbs, and trunk, and consisted of aggregations of papules which were either comedo-like or spinous." Surely there is nothing in this to distinguish it from lichen scrofulosorum?

Another case, a boy, aged 13, was an example of the keratosis pilaris of Brock (xérodermæ pilaire of

Besnier). This case appears to have been similar to the preceding, but that there were no spines and no aggregation into patches.

In a third case of Dr. Fox's the patient was a boy, aged 3½, and the diagnosis given was lichen scrofulosorum. The boy had a corneal ulcer and slightly enlarged glands in the neck. Pulmonary tuberculosis was suspected. A follicular eruption occupied all the trunk, the lower part of the neck, and the thighs. Dr. Fox remarks: "The case was somewhat unusual, in that the eruption was so copious that only slight indications of aggregations in patches were observable." He adds: "Very frequently lichen scrofulosorum is grouped like the lichen spinulosus of Devergie. There were no spines, though little adherent scales simulated spines."

Dr. Fox illustrated this eruption by the drawing of another very similar case, in which large glands in the neck were removed, and proved to be tuberculous.

At the same meeting that the cases just quoted were exhibited, Dr. James Galloway showed a boy, aged 3, who had a profuse follicular eruption involving almost the whole surface. The papules were situated round the sweat or hair follicles, the centre of each in the earlier stage of the eruption being marked by the orifice of a duct or a small hair. The lesions had lasted for five months, and had caused little or no inconvenience to the child. There was practically no irritation nor any marks of scratching. The child had at one time been badly fed, but was now apparently in good health. Although such diagnoses as lichen planus and lichen urticatus had been given in this case, it may perhaps be fairly claimed as probably one of the group with which we are dealing.

In 1896, Dr. (now Sir) E. C. Perry presented a case with the diagnosis of lichen spinulosus. The patient was a boy, aged 14. The eruption consisted of an innumerable number of small papules, from the centre of which stood out bristles about one eighth of an inch in length. It involved the front and sides of the neck, the shoulders, arms, and axillæ, as well as the entire trunk. The patient stated that he had had it for six months, that it had first started on the arms, and that it had itched very little. In the early stage there was some slight congestion around the papule, but as the spine developed and the lesion grew older the colour died away.

At p. 297 of vol. xii. is a narrative by Dr. Pringle of "a somewhat aberrant case of lichen spinulosus vel pilaris in a girl, aged 8. The eruption had begun on the legs, and was of nearly three months' duration. It had produced typical large plaques, with projecting horny spines, giving a nutmeg-grater-like sensation on palpation."

There was a patch also on the back of the neck, and the whole of the back was thickly studded with the spiny lesions arranged either in minute groups or scattered singly. In the early stage of the papules a pink zone surrounded them.

Dr. Whitfield has recorded, on p. 293 of vol. xv., the case of a boy, aged 13, who had patches of eruption on his right wrist and on both legs. The patches had been present many years. That on the wrist was circular and an inch in diameter. Those on the legs were diagnosed as lichen planus, the lesions being uniformly follicular in site, and carrying in every instance a small follicular spine. There were also some patches of "verrucose lichen planus" on the shins.

The diagnosis given was of a tubercular affection on the wrist and lichen planus on the legs, but as both conditions had commenced at the same time it seems equally probable that they were of the same nature, and possibly examples of a chronic type of lichen scrofulosorum.

This view is strengthened by the circumstance that a subsequent report recorded that the patch on the wrist was surrounded by minute papules in the hair follicles around it.

The case is of value as illustrating the transition of a chronic lichen spinulosus into the so-called "verrucous" form of lichen planus. It may be reasonably doubted whether this form has any real affinity with typical lichen planus.

A case of lichen scrofulosorum in a little girl who suffered from ulcerating lupus of the nose was brought before the Dermatological Society by Dr. Graham Little. Her eruption had been present only four weeks, and had appeared on the trunk as groups of small pink, rather spiny papules. The papules were obviously follicular in position and gave rise to no objective symptoms. The groups were numerous on the back, but were present in other regions. Microscopic examination did not reveal any evidence of tuberculosis.

In some observations recorded by Petersen in 1893, he states, "The essential feature of this disease

consists in blackish, horny excrescences, occurring separately and also in masses. In the latter case a plateau of large size results. A considerable area of the body's surface may be involved."

Petersen was writing concerning Darier's disease, "psorospermose folliculaire végétante." Apparently he had repeatedly recognized the so-called coccidia, and he gives substantial reasons for not believing in their parasitic nature.

Dr. Boeck, of Christiania, described a case which he regarded as a typical example of Darier's malady, and of which a man, aged 47, was the subject. The condition had been present 16 years, and covered the whole body with papules, varying in size from a millet to a hemp seed, which were covered with epidermic scales. The microscope showed numerous encysted coccidia in the epidermis, especially in the stratum granulosum. Subsequently, Dr. Boeck showed two sons of the same patient who were suffering from the same disease, and made the interesting statement that in the early stages he had found the malady quite amenable to treatment. His remedy had been a pyrogallic ointment.

As regards the positions affected, Dr. Boeck, who analysed four cases, says that the hairy parts were more especially affected, and mentions particularly the backs of the hands and neighbouring parts of the forearm. He says that in all four cases the face was involved, particularly the forehead, and mentions that the parts of the cheek near the nose and chin were especially involved.

The nails he describes as being always more or less attacked, being striated and friable, and mentions that the skin around them may remain quite sound whilst they suffer.

A very full account of the different stages of the malady is given by him, and well summarised in the supplement of the 'British Medical Journal' for Dec. 19, 1891.

Dr. Boeck's final conclusion was that Darier's coccidia were not zoospores, but simply the results of degeneration: "Premature and irregular cornification of epidermic cells."

In 1891 Dr. Lustgarten (U.S.A.) published the case of a man, aged 49, in whom these coccidia-like bodies had been found. In this case, on the body the lesions presented a marked papillary character, and were mostly discrete, but in some parts they were near together and became confluent, forming small groups or constituting a large oval patch healed in the centre. The skin of the face was greasy and pigmented. Its follicles were dilated and filled with a yellowish-brown fatty brittle substance, which usually rose but slightly above the level of the skin. The coccidia were found in the plugs squeezed out of the follicles.

Dr. Lustgarten made patient experiments as regards the propagation of the coccidia, but, like Darier, wholly without result.

As regards the positions most usually occupied by the eruption, Neumann has recorded the affection in a female, aged 17, in whom the disease had existed three years. The eruption was pretty general over the whole body, but more abundant over the sternal region, between the shoulders, on the lateral regions of the chest, and on the dorsal surfaces of the feet. It affected also the axillary and inguinal regions.

Professor Schwimmer, of Buda-Pesth, recorded in 1891 a case in which "the papules in every stage showed abundant psorosperms."

The eruption is stated to have lasted some months, and to have involved the whole surface, affecting most severely the parts which have been mentioned in other cases. The palms and the soles were free. The patient is stated to have been in good health when first seen. Arsenic was used both by the mouth and subcutaneously. The patient began to suffer from digestive troubles, and her health failed. She returned home, and died two months later. The eruption had been pruriginous.

The papules are described as having been discrete, with an umbilicated apex, sometimes horny and sometimes covered with scab. On the face, especially in the naso-labial folds, gaping sebaceous orifices were present. There were numerous papules in the concha of the ear, which interfered with hearing and were destroyed by the cautery. We have here, apparently, an example of the acute form of the disease ending fatally, but there may possibly be some error as to duration, and in reference to the result the measures of treatment must not be forgotten. There seems but little doubt that the case was really one of Darier's dermatosis.

Dr. Prince Morrow has published as an example of keratosis follicularis an important case which has the advantage of being illustrated by woodcuts. His patient was a sailor, aged 21, in whom the eruption had been present five years, and who believed that it was always aggravated when he was at sea. It was associated, but probably as a mere matter of coincidence, with a sore tongue and some whitish patches in the buccal pouches.

Dr. Morrow writes: "The most interesting clinical feature of this case was the implication of almost the entire folliculation of the skin in a morbid process, which has resulted in a dilatation and projection of the excretory ducts and the presence of comedo-like plugs, which were altered in character and exaggerated in development."

Dr. Morrow's narrative is accompanied by a detailed statement of the morbid anatomy by Dr. A. R. Robinson.

Dr. Elliott, of New York, in 1894, produced before the New York Dermatological Society a Russian boy, aged 14, who had been for more that four years the subject of this malady. The eruption had begun on the back, and having spread had now partially covered the face, trunk, and extremities. The lesions, for the most part discrete, were in some places aggregated to form large areas. They were pin-head in size, but also larger, were slightly elevated, were of a pale or reddish colour, and contained in their centres a dark hard adherent plug. There were no pronounced spines or horny prolongations. On the backs of the hands were large pea-sized fleshy papules, dark red in colour, bearing upon their central portions brown or greenish crusts, which were firmly adherent and occupied more or less shallow pits.

Conclusions.

It may, in conclusion, be suggested that the opinions and facts above cited, if carefully weighed, would lead to the following conclusions:—

1. That there is an affection of the skin more or less persistent which is characterized by the formation of indolent lichenoid papules, which is definitely in association with tuberculosis.

2. That the presence of comedones and of spines are non-essential conditions which may be present in some cases and absent in others.

3. That the anatomical seat of the characteristic papule is the orifice of a hair follicle, but that the dermatitis may implicate other structures, and may vary in its characters in different parts of the same patient's skin.

4. That the affection may be sub-acute or very chronic.

5. That there is no better name for the various forms of this malady than that given to it by Hebra—the lichen of the scrofulous.

6. That under the name of lichen scrofulosorum may suitably be placed most examples of chronic comedonous lichen—the so-called Darier's Dermatosis; the lichen of Devergie, lichen pilaris; lichen spinulosus; and some others, as well as the slighter forms already recognized by British dermatologists as L. scrofulosorum.

7. That, inasmuch as certain cases of lichen scrofulosorum, especially if neglected, tend to persist for years and become self-aggravated while others are quite transitory, the term lichen scrofulosorum diutinum may suitably be employed to distinguish them.

8. That the so-called coccidia of Darier's malady are present only in very chronic cases, and are the results of degenerative changes.

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FASCICULUS XXVII.

DISEASES OF OVARY, FALLOPIAN TUBE, UTERUS, &c.

PLATE CLXXV.—Tubercular Disease of the Fallopian Tubes; Gonorrhœal Pyosalpinx; Hydrosalpinx.

„ CLXXVI.—Tubal Abortion; Hæmatosalpinx.

„ CLXXVII.—Multiple Fibro-myomata of the Uterus.

„ CLXXVIII.—Hæmorrhagic Carcinoma of the Ovary.

„ CLXXIX.—Procidentia Uteri.

„ CLXXX.—Squamous-celled Carcinoma of Labium.

„ CLXXXI.—Syphilis of Vulva and Mouth.

„ CLXXXII.—Syphilis of Vulva and Lips.

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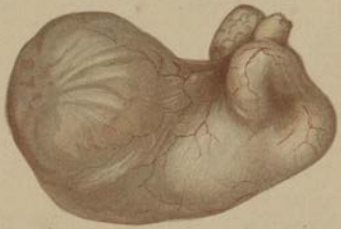


PLATE CLXXV.*

TUBERCULAR DISEASE OF THE FALLOPIAN TUBES.

The uppermost figure represents the left Fallopian tube and ovary removed by operation on December 24th, 1889, from a woman, aged 30, who was said to have been at the age of eleven years threatened with pulmonary consumption, and to have recovered and remained well till married in April, 1889. In July of that year she aborted at the third month and progressed satisfactorily for a week, when she began to suffer from severe pain in the pelvis. This recurred from time to time up to December. She was then ill and emaciated, with a purulent discharge from the uterus and evidence of enlarged and adherent Fallopian tubes. There were signs of old mischief at the apex of one lung. The diagnosis was made of tubercular disease of the uterus and Fallopian tubes. Abdominal section was performed and both Fallopian tubes were removed, the right being even more diseased than the left. The pelvis was found entirely occupied by adherent viscera and thickened peritoneum studded with miliary tubercles.

The drawing shows the enlarged, sacculated, and tortuous left tube, with numerous miliary tubercles on the peritoneal covering of the tube and on the meso-salpinx. On the ovary, which is of normal size, are several small subserous cysts. The tubes were filled with caseating pus, lying in ulcerated pits.

[From Cullingworth's "Diseases of the Fallopian Tubes," p. 7. For full notes of this case see a paper on "The Differential Diagnosis of Pelvic Inflammation," *British Medical Journal*, December 27th, 1890.]

GONORRHŒAL PYOSALPINX.

The middle figure shows the right Fallopian tube and ovary removed, along with the uterine appendages of the opposite side, on February 18th, 1892, from a ballet dancer, aged 18 years. The patient was single, but had been living an irregular life for the past six months. Three weeks before admission into the hospital she was seized with pain in the lower part of the abdomen, followed by vomiting. A yellow vaginal discharge began about the same time. She remained in bed for a week and improved, but had to return to and keep her bed a few days later, as the pain returned. On admission there were fixed, irregular swellings, traceable from the cornua of the uterus, felt in the posterior fossæ of the pelvis. Some muco-pus was seen in the vagina and about the vulva. There was no urethritis or inflammation of the vulvo-vaginal gland ducts. Pus, which proved to contain gonococci, was seen issuing from the os uteri. There was no erosion of the cervix.

At the operation both Fallopian tubes were found acutely inflamed and buried amongst adherent viscera. The patient made a good recovery.

On section the cavity of the tube was found to be distended and tortuous. At its fimbriated end it had a diameter of three-quarters of an inch. It was filled with pus. The folds of mucous membrane showed no ulceration, but were swollen, abnormally voluminous, and coloured yellow from infiltration with pus. In the ovary there were three small cysts; two of these were filled with recently-extravasated blood; the third was filled with pus.

[From Cullingworth's "Diseases of the Fallopian Tubes," which contains a coloured plate exhibiting the condition seen on section. Plate III., fig. 1.]

* *Plates CLXXV. to CLXXX. inclusive are from drawings kindly lent for the purpose by Dr. Cullingworth.*

HYDROSALPINX.

The Fallopian tube, in this affection, becomes occluded at its fimbriated end, usually from a localised peritonitis originating in disease of some other part of the pelvis, not unfrequently in purulent inflammation of the tube on the opposite side. The closed tube subsequently becomes distended with serum, thus forming a retention cyst. The tube itself being as a rule otherwise free from disease, its walls become stretched and attenuated, the folds of the mucous membrane more or less obliterated and the muscular coat atrophied. The distended tube may reach an enormous size, as in a specimen preserved in the St. Thomas's Hospital Museum, but it has been thought better to illustrate the condition by a drawing of a specimen of more moderate dimensions, as being of more frequent occurrence and therefore more typical.

The lowest figure shows the right Fallopian tube distended and much convoluted, removed January 25th, 1895, from a patient, aged 49, who had had an attack of pelvic peritonitis two years previously, and several less serious attacks subsequently. There was a smooth, tense, elastic fluctuating swelling in the lower part of the abdomen, situated centrally, with the uterus to the left of it and behind. A smaller cystic swelling was felt in Douglas's pouch. The larger tumour proved to be a large hydrosalpinx of the left tube containing thirty-two fluid ounces of clear watery fluid of sp. gr. 1008, alkaline and containing a trace of albumen. The smaller tumour, a hydrosalpinx of the right tube, is represented in the drawing. It shows the retort-shaped expansion usually seen at the outer end of the tube, and the complicated convolutions often met with in the median and inner portions. The origin of the peritonitis in this case is not known.

[From Cullingworth's "Diseases of the Fallopian Tubes," page 1.]

PLATE CLXXVI.

HÆMATOSALPINX.

TUBAL ABORTION.

The upper figure is a drawing of a firm blood-clot, laid open, and displaying in its interior an embryo in its amniotic sac. The specimen was removed by operation on December 1st, 1894, from the pelvis of a woman suffering from extensive intra-peritoneal hæmorrhage.

The clot measures 6 cm. ($2\frac{1}{2}$ inches) × 4·5 cm. ($1\frac{3}{4}$ inches), and is firm and homogeneous. The embryo is seen near one end of it. The procurved trunk measures, in a straight line, 8 mm., and presents undivided, simple lower limbs and a sharply-curved caudal extremity. The umbilical vesicle has been detached; above its remains there protrudes a well-developed heart.

The embryo corresponds in its development to one between the third and fourth week.

The specimen was exhibited at the Obstetrical Society of London on April 6th, 1895, and is now in the Museum of St. Thomas's Hospital.

The history of the case is as follows:—

The patient was 36 years of age. She had been married fifteen years and ten months, but was without children. Menstruation had always been irregular. Her last menstrual period occurred on October 1st and 2nd, 1894. She had been subject to indigestion for two years, but had not suffered from vomiting. For the last three weeks she had vomited in the early morning.

On the evening of Wednesday, November 28th, 1894, she was seized with sudden but not very severe pain in the upper part of the abdomen. She ascribed it to flatulence. After it had continued for two hours she fainted. She became alarmingly ill during the night, and remembers nothing of what occurred. She was told that she fainted a second time between 1 and 2 a.m. She was in pain all the next day, complained much of thirst, and vomited repeatedly. On the 30th she was sent up to the hospital by Dr. Collier, of Wimbledon, as a probable case of ruptured tubal gestation. There had been a slight discharge of blood *per vaginam* since the previous day.

On admission she was very pale, and looked extremely ill. Her pulse was rapid and feeble, and she had frequent vomiting of small quantities of mucus. She complained of no pain, and the abdomen was not distended. Vaginal examination showed the uterus to be freely movable, of normal size, and displaced to the left of the middle line. The vaginal roof on the right side was slightly depressed by an ill-defined softish swelling, such as would be caused by soft blood-clot.

No urine had been passed since the morning of the previous day. The bladder was empty.

A consultation was held, and it was decided to administer nutritive and stimulating enemata, and to open the abdomen early the following morning if she had rallied sufficiently.

During the night the catheter was passed twice; on one occasion $1\frac{1}{2}$ fl. oz., and on the other 3 fl. oz. of urine being withdrawn.

At 10 a.m. on December 1st abdominal section was performed. A quantity of dark blood, chiefly fluid, but partly clotted, was found free in the peritoneal cavity. About 28 fl. oz. were collected and measured; some, of course, escaped. Behind the uterus and at the fimbriated end of the right Fallopian tube, to which it was lightly attached, was found the blood-clot shown in the drawing. On grasping it it came away loose in the hand. There were no adhesions. The right tube and ovary were quickly removed. Though the operation only lasted twenty minutes, the patient ceased to breathe before its termination. She revived somewhat on discontinuing the anæsthetic, and a pint and a half of saline solution was injected into one of the veins of the upper arm. When the patient was put back to bed the pulse was distinctly perceptible and the body warm. About 2 p.m. she became delirious, flushed, and restless. After a time she fell asleep, but about 5.30 p.m. the breathing became noisy and difficult from ineffectual efforts to clear the air passages of mucus. She died at 7.45 p.m., apparently from suffocation.

The portion of Fallopian tube removed was found on examination to be quite empty. No trace of a decidual lining was to be seen. The fimbriated end was open, and the lumen of the outer part of the tube was sufficiently dilated to admit the finger. There was a little inflammatory lymph on the outer surface of the tube.

The ovary removed presented a *corpus luteum* half an inch in diameter.

At the autopsy the uterus was found to be very little above the normal size. The body was lined by a distinct decidual membrane which was everywhere adherent to the uterine wall. It ceased abruptly at the *os internum*. The left tube and ovary were normal.

This is an indisputable case of complete tubal abortion. It possesses special interest on that account, and because of the extreme rarity of specimens with an embryo in so early a stage of development.

[The above description is taken from Cullingworth's "Diseases of Fallopian Tubes," pp. 47-51.]

HÆMATOSALPINX WITH HÆMATOCELE; PROBABLE TUBAL ABORTION.

The lower figure represents a right Fallopian tube distended with firm clot, removed by operation, June 27th, 1889. The abdominal ostium is widely dilated, and clot is hanging from it. The fimbriæ were folded back upon the exterior of the tube; in the drawing they appear unfolded as when the specimen was placed in water. The tube was surrounded by a quantity of fluid and clotted blood, measuring thirty fluid ounces, and forming an intra-peritoneal hæmatocele. A firm coat of adherent blood-clot had been deposited on the entire surface of the tube. A portion of this has been removed to show the smooth peritoneal surface beneath. Though examination of one-half the clot gave negative results, yet I think the case is probably one of early tubal gestation.

The history of the case is as follows:—

N. B., aged 33, was admitted into hospital June 8th, 1889. She was married at the age of sixteen, and had borne four children and had one miscarriage. Her last child was born nine years ago. Menstruation was regular up to the commencement of the present illness. For six weeks previous to her admission she had continuous uterine hæmorrhage. Five days before admission, and again on the day preceding admission, she was suddenly seized with acute abdominal pain, rectal and vesical tenesmus, vomiting, and alarming faintness. Similar symptoms presented themselves on the eighth day after admission, and again on the sixteenth. On the morning of the day on which she sought admission, the hæmorrhage, which had hitherto been slight, became profuse, and a "whitish lump" (*? decidua*) was passed *per vaginam*.

The physical signs on admission were those of (intra-peritoneal) pelvic hæmatocele. The recurrence of the symptoms of fresh internal hæmorrhage determined me to open the abdomen. Thirty fluid ounces of fluid and clotted blood were found within the peritoneal cavity, shut off from its upper part by a thick roof composed of omentum infiltrated with blood-clot. The right Fallopian tube was in the midst of the hæmatocele, and was itself evenly distended with firm blood-clot. Its uterine end was normal. Its distal end was widely open, and dark clots protruded from it. The diameter of the abdominal ostium was an inch; the fimbriæ were folded back upon the outer surface of the tube, which was surrounded by a thick coat of firm, adherent blood-clot. The walls of the tube were healthy. The portion of tube removed measured three inches in length and two in width.

The patient made a good recovery, though not without some pelvic suppuration and the formation of a sinus which ultimately closed six months afterwards, on the escape of a silk ligature.

The contents of the tube and the blood from the hæmatocele were carefully examined, but no products of conception were discovered.

Notwithstanding the absence of pathological confirmation, there are several facts in favour of supposing this to be a case of early tubal abortion with hæmatocele, *e.g.* (1) the long interval that had elapsed since the last pregnancy, and (2) the absence of inflammatory change in the walls of the distended tube or other morbid condition likely to be a source of hæmorrhage.

There is no history of missed menstruation, but this may be explained by supposing that the abortion occurred during the first month of gestation.

The specimen was exhibited at the Obstetrical Society of London, and is described in its *Transactions*, vol. xxxi., for 1889, page 226. It is now in the Museum of St. Thomas's Hospital (No. 2479). Full details of the case will be found in the *St. Thomas's Hospital Reports*, vol. xix., page 182.

[The above description is taken from Cullingworth's "Diseases of Fallopian Tubes," pp. 34-37.]

PLATE CLXXVII.

MULTIPLE FIBRO-MYOMATA OF THE UTERUS.

The specimen consisted of a symmetrically enlarged uterus divided longitudinally, and showing in section from thirty to forty hard fibro-myomata in the muscular tissue. The tumours varied in size from that of a pea to that of a hen's egg, and the surrounding muscular tissue was greatly hypertrophied. The uterine cavity was much dilated. At the lower part of the specimen (which had been removed above the vaginal insertion of the cervix on November 20th by abdominal hysterectomy) several tumours of about the size of a pigeon's egg were seen projecting from the outer surface of the main mass. These had been enucleated from between the folds of the broad ligaments and other pelvic tissues, into which they had burrowed. The mass measured 7 inches in length, 7 inches in width, and $4\frac{1}{2}$ inches in depth antero-posteriorly. The length of the uterine canal was 5 inches. The weight of the mass was 5 lbs. A water-colour drawing of the specimen in its fresh state (the original from which this plate is taken) was exhibited with the preparation.

The patient was a lady, aged 43, who had been married fifteen years, and had never been pregnant. She had menstruated profusely during the whole of her married life, and for the last seven years had been a confirmed invalid, spending at least five days of every month in bed on account of the excessive and increasing monthly loss. She was extremely anæmic, and her mental condition was unsatisfactory. Considering that some years must elapse before the menopause it was thought right to place before her the chance of cure by operation. The immediate risk was explained, and after consultation with her friends she decided to face it.

The operation was performed by Dr. C. J. Cullingworth by what is known as Baer's method, and presented no special difficulties except such as were caused by the burrowing of outgrowths in the surrounding tissues.

Convalescence proceeded satisfactorily for five days and there seemed every prospect of a successful issue. But on the morning of the sixth day the patient became suddenly collapsed, and died in a few hours. At the post-mortem examination no cause for the collapse was discovered. There was no hæmorrhage, or peritonitis, or evidence of septicæmia. The descending colon and rectum were collapsed and empty; the intestine above was slightly distended, but not sufficiently so to cause any marked fulness of the abdomen.

The result was extremely disappointing and difficult to account for.

The specimen was exhibited, however, not so much on account of the clinical as of the pathological interest of the case, it being unusual to find such a symmetrical enlargement of the uterus due to a number of small tumours.

[From the London Obstetrical Society's *Transactions*, 1896, vol. 38, p. 6.]

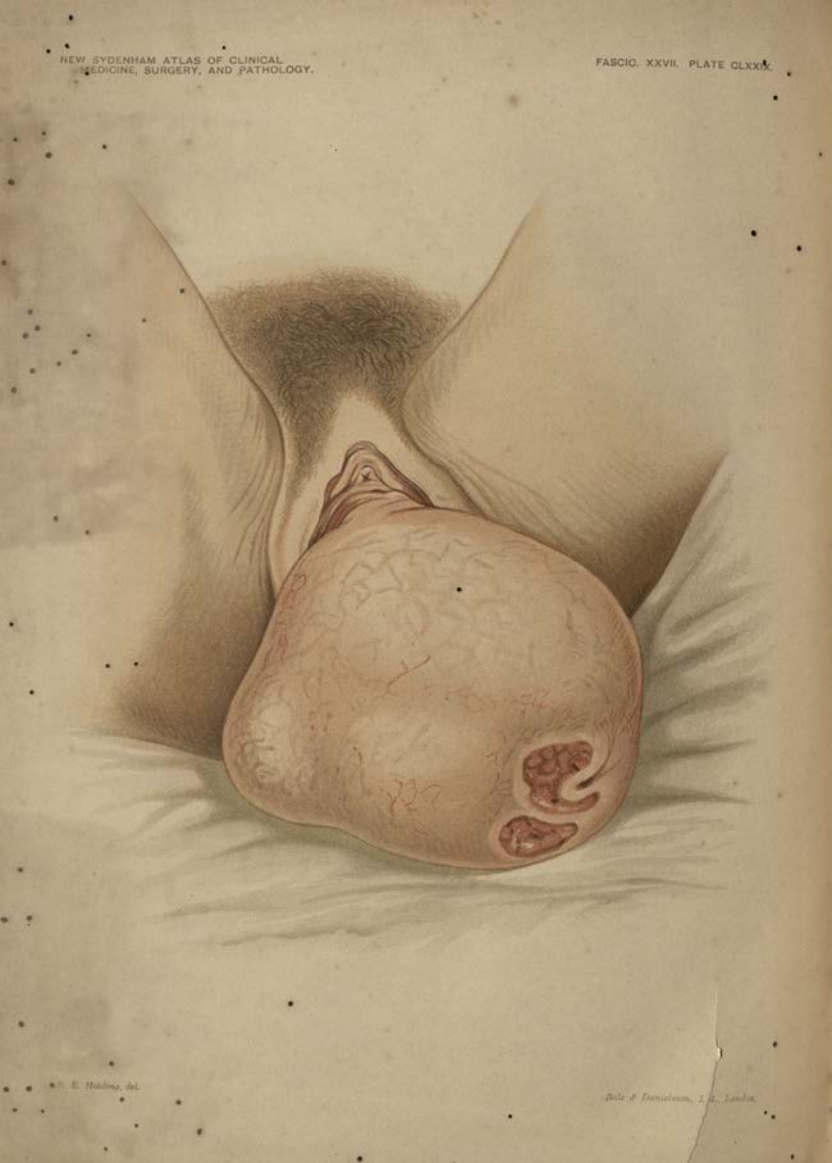
PLATE CLXXVIII.

HÆMORRHAGIC CARCINOMA OF THE OVARY.

The main portion of the tumour consists of a large cyst cavity, measuring six inches by four inches, filled with brownish-red blood clot. The cyst wall had given way, and blood had been poured out into the peritoneal cavity, giving a deep red colour to the ascitic fluid which it already contained. The condition is not uncommon in the kidney, but in the ovary it is believed to be exceedingly rare.

The tumour was removed by Dr. C. J. Cullingworth on September 17th, 1891. No ill effects followed the operation, but the patient gradually lost flesh and strength, and died from extension of the disease at the end of October.

[From the London Obstetrical Society's *Transactions*, 1891, vol 33, p. 445.]



M. E. Hadding, del.

Bale & Danielsson, Ltd., London.

PLATE CLXXIX.

PROCIDENTIA UTERI.

This figure shows an extreme degree of procidentia uteri, the prolapsed mass consisting of almost the entire vagina, the whole of the uterus and its appendages, and the bladder, together with several coils of intestine. The well-defined patches of superficial ulceration are the result of friction.

(Dr. C. J. Cullingworth.)

W.E. Holding, del.

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PLATE CLXXX.

SQUAMOUS-CELLED CARCINOMA OF LABIUM.

Upper Figure.

The patient was an unmarried lady, aged 56 years. Menstruation had ceased for four years. Three years before coming under observation she had noticed a small sore place on the right labium minus; this became hard and increased in size. For a few months it had been painful. For about thirty years she had had irritation at the vulva, the parts chafing very readily. There was no vaginal discharge or loss of flesh.

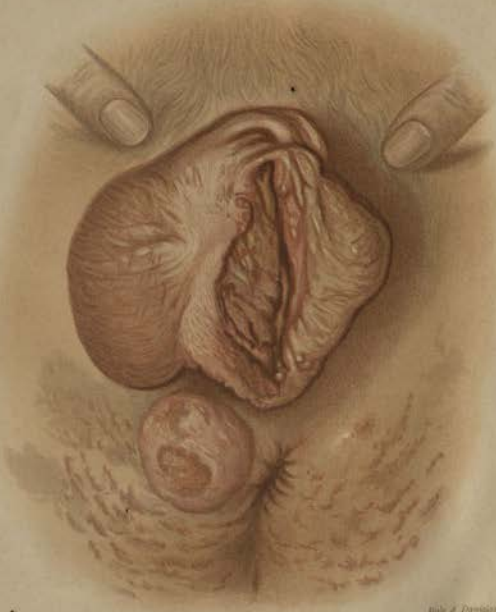
When seen by Dr. Cullingworth on March 9th, 1893, there was a soft growth on the right labium minus, close to the clitoris, of about the size of a cherry. There was also a small abraded surface on the left labium minus, about the middle of the vaginal orifice. The uterus was normal. There were some slightly enlarged glands in the right groin. The tumour was removed on March 16th, together with two inguinal glands. Three years later there was no recurrence; but in 1901, 1903 and 1904, recurrent growths were removed from the vulva, mainly on the right labium majus.

Lower Figure.

The patient was a married lady, aged 50 years. She had had nine children and one miscarriage, and a phantom pregnancy occurred seven years before coming under observation. She had been getting thinner for some months despite a good appetite. She had suffered from a good deal of mental stress for some years. Menstruation had been regular up till nine months previous, since then it had only occurred twice. She stated that she had had ulcers on one labium several times at intervals for the past fifteen years. Six months before examination she noticed a sore on the labium with some swelling and eversion, for which she lay up and consulted a medical man. When first seen by Dr. Cullingworth on May 21st, 1889, there were several circular abrasions on the left labium with no induration of margins and no enlargement of the glands in the groin. They were extremely tender. Two or three non-sensitive abrasions were present on the right labium. Vagina and uterus normal.

Under local treatment a certain amount of healing took place, but the lower abraded surface showed a good deal of hardening, and its malignant character became apparent. After a consultation with Mr. Jonathan Hutchinson on July 27th it was decided to remove the left labium and the mucous membrane of the right. This was done and the growth was reported by Mr. Shattock to be a squamous-celled carcinoma.

The wound healed rapidly. By February, 1890, a mass of glands had developed in the left groin as large as a pigeon's egg, with a few small, hard glands in the right groin. There was no local recurrence. The glands were removed. In December, 1890, a malignant ulcer appeared on the perineum just in front of the anus; it was about the size of a shilling with an indurated base; operation was declined and the patient died in August, 1892, three years and nine months from the first appearance of the ulcer.



Hall & Davenport, Lith., London.

PLATE CLXXXI.

SYPHILIS OF VULVA AND MOUTH.

The two figures are from the same patient, E.B., aged 22, admitted to the London Hospital in 1885. She contracted syphilis in 1883.

The upper lip, the palate and the tongue were superficially ulcerated. The lip was swollen, reddened and covered with crusts, the condition extending exactly to the middle of the upper lip, the abrupt unilateral limitation suggesting that it was herpetic in nature. The ulceration of the tongue is restricted to its right half. On the palate the condition is most marked on the right side, but not restricted to it.

In the vulva the right labium minus was much enlarged and pear shaped. Its mucous surface was ulcerated, as was also the opposing surface of the left.

A rounded swelling with superficial ulceration was situated to the right of the anus; this condition was obviously syphilitic and very possibly herpetic.

The hypertrophied labium minus was excised by Mr. Peskett.

Plates CLXXXI. and CLXXXII. are from drawings by Mr. Burgess, kindly lent for the purpose by Dr. Herman.

PLATE CLXXXII.

SYPHILIS OF VULVA AND LIPS.

These two figures were from the same patient, Mrs. S., aged 37, an inpatient at the London Hospital in November, 1883. She was in the secondary stage of syphilis. It will be seen that the lips are inflamed and swollen, the lower one especially so. On the front half of the prolabium of the latter there is a row of thin adherent crusts. At the left angle of the mouth there is an ulceration with elevated bossy margins of condylomatous type.

On the vulva the inner part of the right labium is involved in a large ulcer which has a sinuous elevated border and a grey base. Around the ulcer the parts are swollen and much congested.

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OF THE

ATLAS OF CLINICAL MEDICINE, SURGERY, & PATHOLOGY.

COMPILED FOR

THE NEW SYDENHAM SOCIETY.

By E. W. HEDLEY, M.A., M.D., B.C.Cantab.

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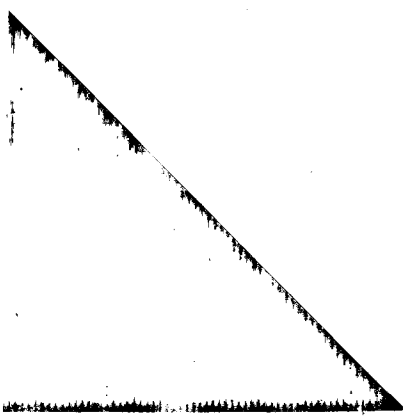

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